October 4, 2002

Kentucky Public Employee Health Insurance Forum

Agenda

- Background
- The Insurance Market
- The Public Employee Health Insurance Program
- Health Plans Today
- Healthcare Challenges in the Millennium
- Commonwealth Group: Major Challenges
- Employee Advisory Council Presentation
- Employer Health Insurance in the Millennium
- Wrap Up

Background

- How Health Insurance Premiums are Determined
- Averages are Misleading
- Health Insurance Trend Components
- Self-Funding Considerations

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How Insurance Premiums Are Determined

Payments to Medical Providers

x

Expected Health Insurance Trend

+

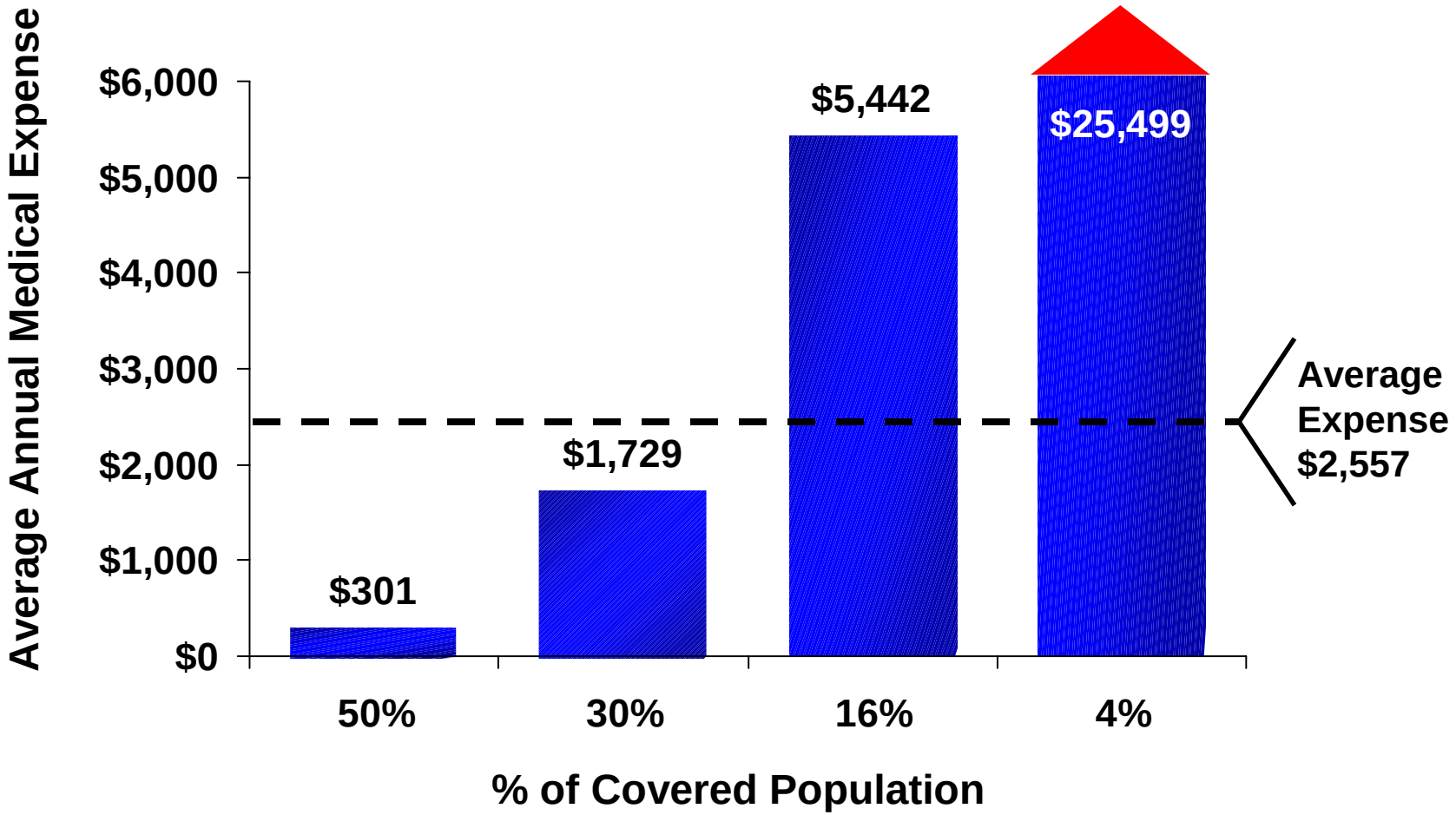
Administration Cost

Health Insurance Premium Calculation
Illustration

Payments to Medical Providers in 2002		$500,000,000
Health Insurance Trend	+	10%
Expected Payments in 2003	=	$550,000,000
Administration Expense	+	$ 50,000,000
Total Expected Cost in 2003	=	$600,000,000
Premiums Collected in 2002		$500,000,000
Percentage Increase		20%

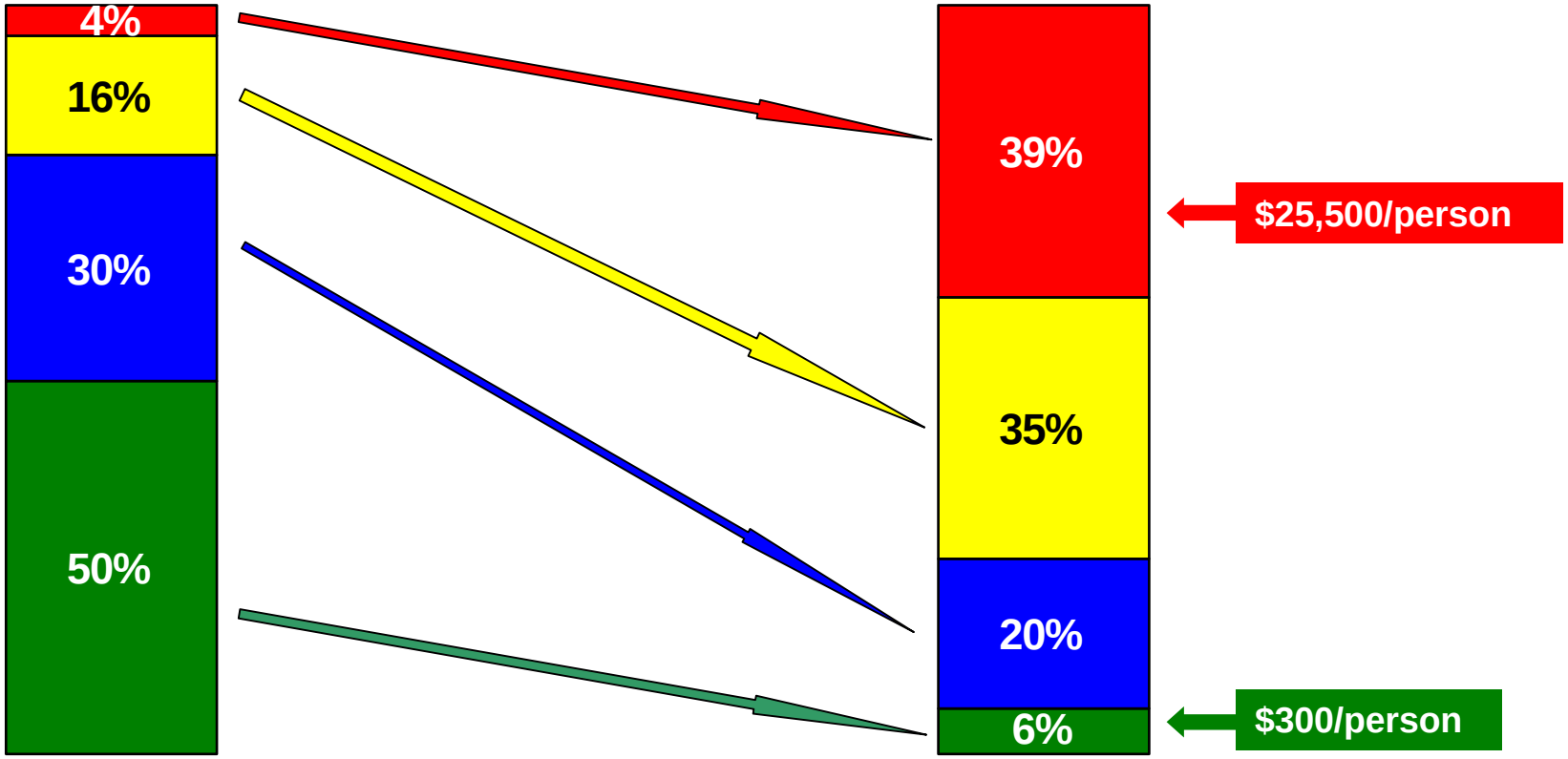
Premium Rates (averages)	**2002**	**2003**
Employee only	$260	$312
Employee & Child(ren)	$390	$468
Employee & Spouse	$585	$702
Employee & Family	$650	$780

Averages Are Misleading

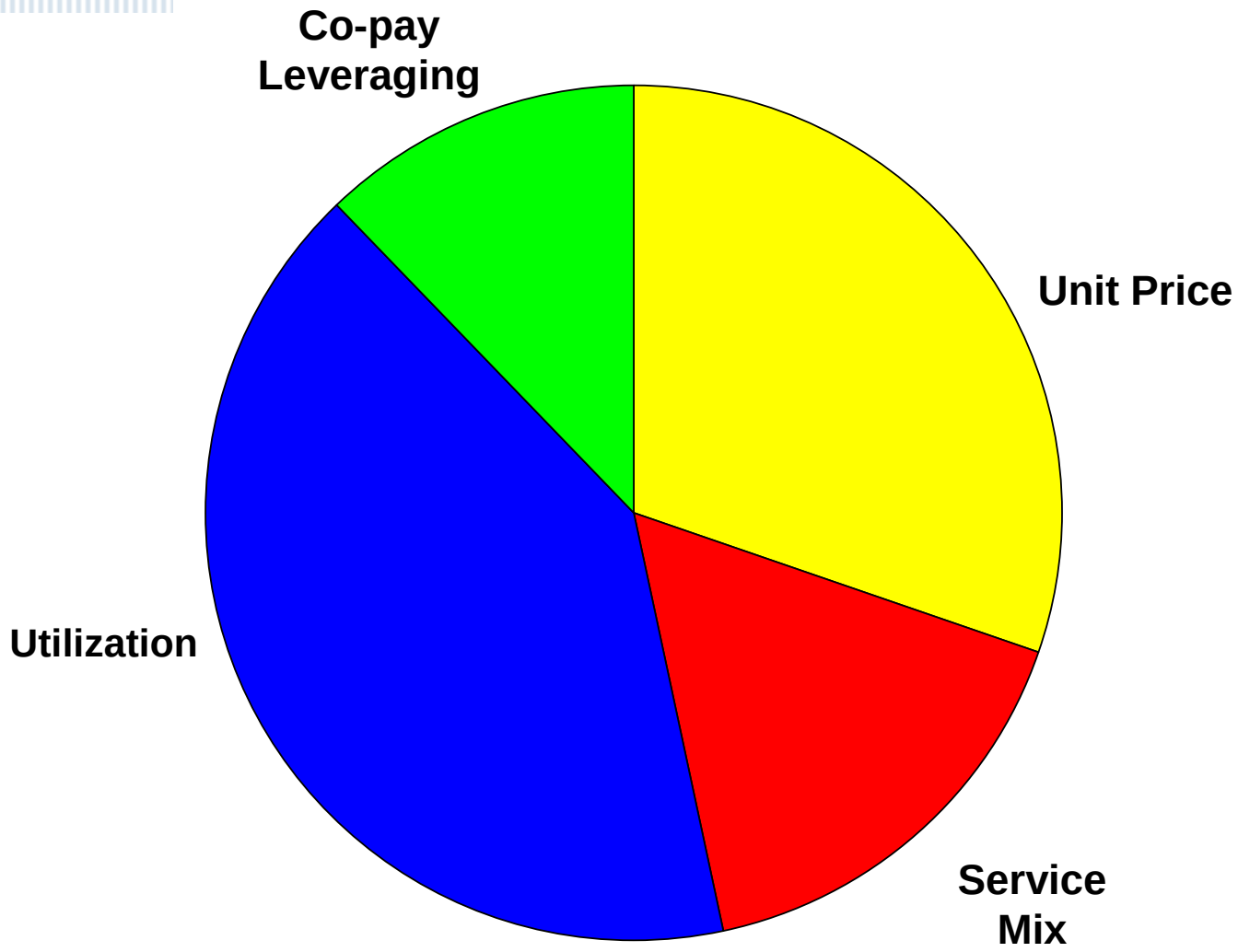


Source: PEHI 2001 allowed charges - 1st quarter 2002 MedStat database

Commonwealth Group Claims Distribution
A small percentage drives cost



Health Insurance Trend Components



Unit Price

		Total Cost
2000	Naproxen	$11.00
2001	Naproxen	$11.63

Unit Price Increase **5.7%**

Service Mix

		Total Cost
2000	Naproxen	$11.00
2001	Celebrex	$83.00
Total Increase %		655%
less	Unit Price Trend	6%
	Service Mix	649%

Utilization

	Average # of Prescriptions Per Person
2000	14.89
2001	16.05
Utilization Increase	**7.8%**

Co-pay Leveraging

	2000	2001	% Increase
Prescription Cost	$50	$53	6%
Copayment	$15	$15	0%
Health Plan Cost	$35	$38	8.6%

Co-pay Leveraging **2.6%**

Self-Funding

- ✓ **Risk Assumption**
- ∅ **Type of Plan**
- ∅ **Self Administration**

Self Funding
Considerations

- – **Risk Assumption**
- – **Network Disruption**
- – **Plan Choices**
- – **Third Party Buffer Loss**
- – **Regional Health Plan Impact**
- – **OPEHI Requirements**

- ± **Expected Costs**
- \+ **Negotiation Flexibility**
- \+ **Design Flexibility**
- \+ **Cost Allocation Flexibility**
- \+ **Customization Ability**
- \+ **Consistency**

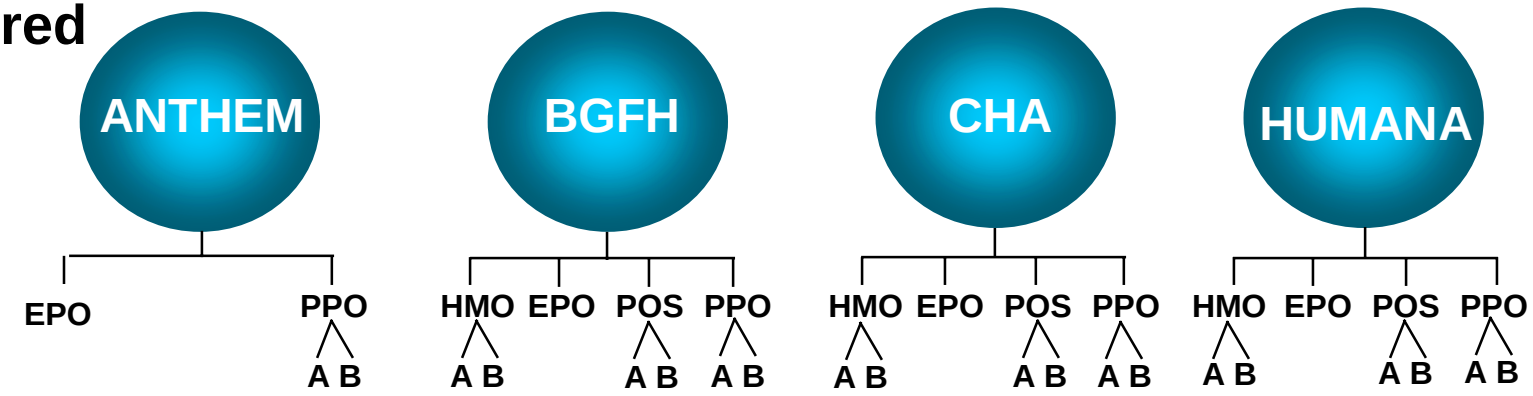
Self Funding
Expected *Costs*

- **Fixed costs**
  - **eliminate risk margin – 2-5% typically**
- **Formulary rebates**
  - **typically 2-3% of Rx claims**
- **Provider network and negotiated payments**
- **Care/claims management**
- **Additional OPEHI resources**
- **2003 Bidding results**

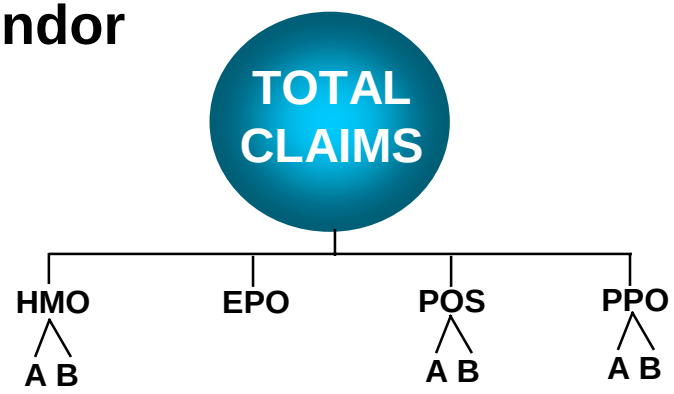
Self Funding

Cost Allocation Flexibility

Current Insured



Self-Funded – One Vendor



Self-Funding

Additional OPEHI Responsibilities

State Employees (UPPS)

KRS

KTRS

School Board Group (183 locations)

Legislators Retirement

Judicial Retirement

KCTCS

COBRA (≈ 1,000)

Health Depts (47 offices)

OPEHI

Claims Administrator

Quasi Agencies (10+)

School Boards (183 locations)

Secretary Miller

The Insurance Market

- **National Insurance Market**
- **Kentucky Health Insurance**

A Look at the General Condition of Insurance Markets

Status of Insurance Markets

- Kentucky is experiencing “hardening of the market” in several insurance lines – specifically property and casualty

- In 2001, property and casualty insurance markets experienced the first full year net loss in 20 years
  - **An overall net loss of $7.9 billion for 2001 vs. an overall net income of $20.6 billion for 2000**

Status of Insurance Markets (con't)

- Factors contributing to the hard market conditions
  - **Increasing claims costs above projected levels**
  - **Increasing loss adjustment expenses and other expenses**
  - **Increasing reinsurance costs due to reduced reinsurance capacity and reinsurance coverage**
  - **Decreasing investment yields**
    - **Unusual situation of significant decreases related to all forms of investments, including both stocks and bonds**

Status of Specific Insurance Lines

- Personal Lines
  - **Homeowners – average rate increases of 12.7%**
  - **Auto – average rate increases of 9%**
- Commercial Lines
  - **Medical malpractice – average rate increases from 15% to 100% depending on physician specialty**
  - **All other lines are experiencing increases**

Reaction of Insurers to Current Hard Market Conditions

What Actions Are Being Taken?

- Premiums are increasing
- Insurers are reducing exposure to risk
  - Nonrenewing business
  - Ceasing to issue new business
  - Limiting the amount of new business written
  - Tightening underwriting standards
- Policy options are limited
  - Lower limits
  - Higher deductibles
  - New coverage exclusions

Why Are These Actions Being Taken?

- An insurer must maintain a level of surplus necessary to meet its contractual obligations
- Surplus is decreased when
  - Claims costs and other expenses rise
  - Unexpected losses, such as a catastrophe, are experienced
  - Investment yields are down
- To increase surplus, an insurer can
  - Increase premium
  - Lessen its exposure to risk

Status of Specific Insurance Lines (con't)

- Health insurance
  - **Average rate increases from 8% to 18%, depending on product type (HMO/POS, PPO)**
  - **Prescription drugs – trends from 20% - 25%**
  - **The rates are stabilizing, but continue to be high**

Taking a Closer Look

Brief History of Kentucky's Health Insurance Market

- Comprehensive health insurance reform (HB 250) was enacted in 1994
  - **Rating reform (modified community rating)**
  - **Guaranteed issue**
  - **Limits on exclusions for pre-existing conditions**
  - **Guaranteed renewability**
  - **Standardized health benefit plans**
  - **Creation of the Kentucky Health Policy Board and the Kentucky Health Purchasing Alliance**

Brief History of Kentucky's Health Insurance Market (con't)

- Following the enactment of HB 250, many insurers made business decisions that had an impact on Kentucky's health insurance market.
- Those decisions created a "crisis" in the market
  - **40+ insurers exited the market**
  - **Only 2 insurers remained in the individual market (Anthem Blue Cross Blue Shield and Kentucky Kare)**

Brief History of Kentucky's Health Insurance Market (con't)

- Additional changes have been made in health insurance laws since HB 250
  - **Return to experience rating**
  - **Addition of mandated benefits (32)**
  - **Network adequacy standards**
  - **Any willing provider law**
  - **Provider contracting requirements**
  - **Prompt pay law**
  - **External review process**
  - **HIPAA**

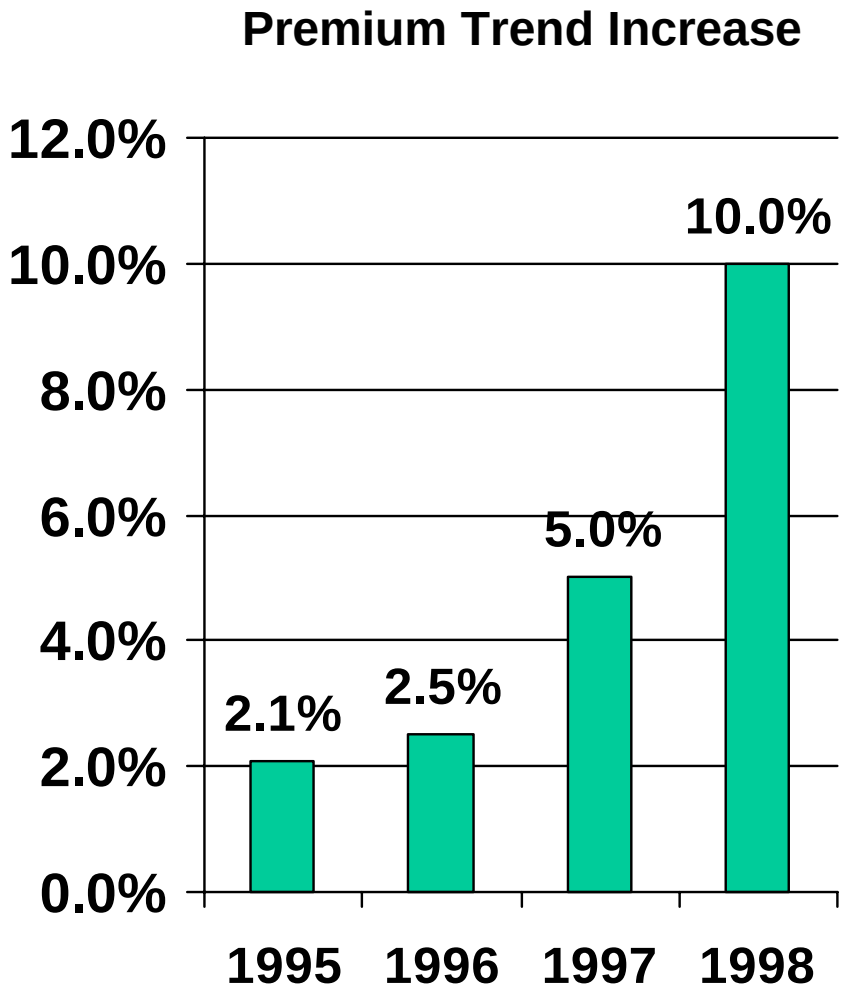
Other Health Insurance Reform Efforts

- There continue to be attempts to address health insurance issues on both the national and state level
  - **Patients' Bill of Rights**
  - **Association Health Plans (AHPs)**
  - **Privacy**

Factors Insurers Consider in Developing Rates

- Trends – utilization and medical cost
- Claims experience
- Administrative costs – profit, overhead and other costs
- Statutory allowances – age, gender, industry and location
- Other factors contributing to rate increases

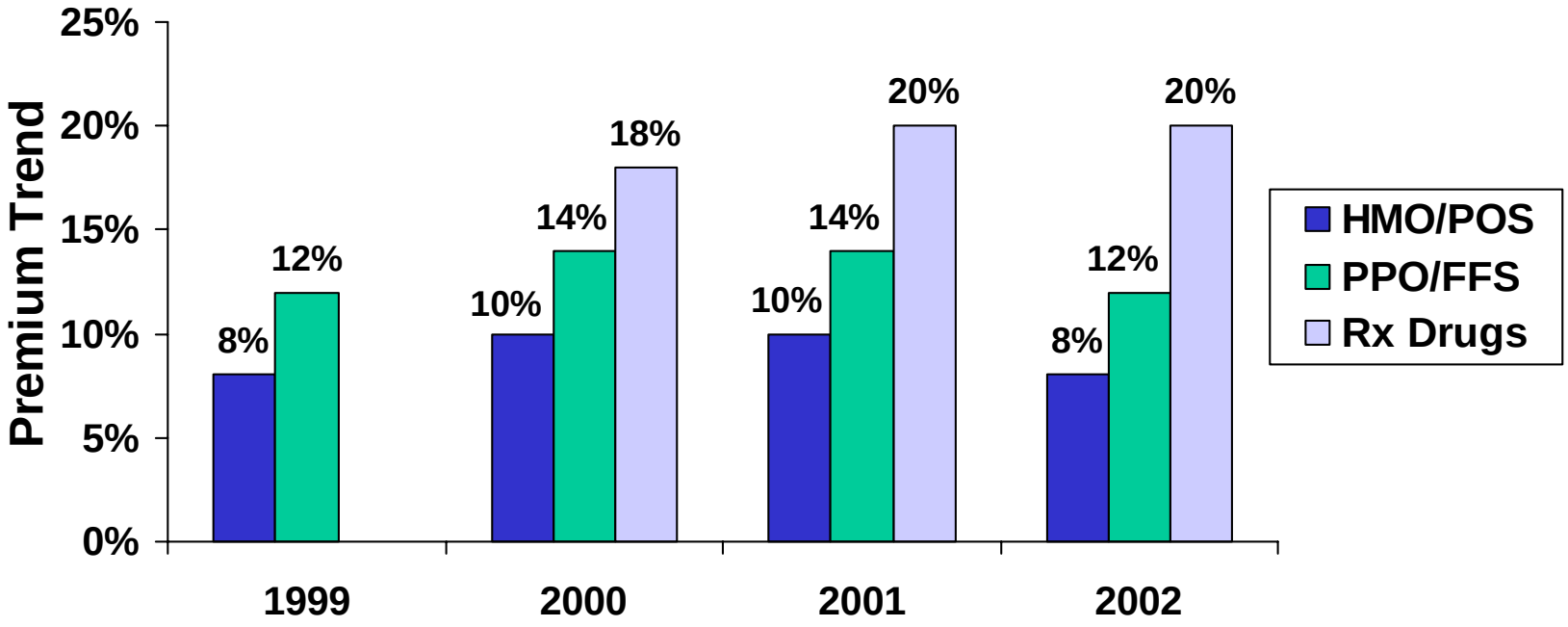
Kentucky Health Benefit Plan Premium Trends



- 1995 – approximately 2.1% increase
- 1996 – approximately 2.5% increase
- 1997 – approximately 5.0% increase
- 1998 – approximately 10.0% increase

Source: *April 1997 Market Report on Health Insurance, Foster Higgins Study*

Kentucky Health Benefit Plan Premium Trends (con't)



Source: Rate Filings made with the Kentucky Department of Insurance

- The data provided for 1999 – 2000 are summary-type statistics and should not be interpreted as being indicative of the increase that any single person would have received.
- The data attempts to provide the best representative trend ranges as possible, but is not inclusive of every filing. A single filing could have trends outside of the identified ranges

Insurers Participating in Kentucky's Private Health Benefit Plan Market

Individual Market

- Anthem Health Plans of Kentucky
- Fortis Insurance Company/John Alden Insurance Company
- Humana
- Mega Life and Health Insurance Company
- Physicians Mutual Insurance Company

Group Market

- Aetna US Healthcare
- Anthem Health Plans of Kentucky
- Bluegrass Family Health
- CHA Health
- General American Life Insurance Company (large group only)
- Humana
- Principal Life Insurance Company (small group only)
- Prudential Health Care Plan, Inc.
- Trustmark Insurance Company
- Unicare Life & Health Insurance Company
- United HealthCare of Ohio, Ltd., United HealthCare of Kentucky, United HealthCare Insurance Co.

Private Group Health Benefit Plan Market - Urban vs. Rural

- **The area in which a type of product is offered (HMO/POS vs. PPO) varies among insurers**
  - Anthem and Humana
    - PPO products offered statewide
    - HMO/POS products offered in limited areas (urban)
  - CHA and Bluegrass Family Health
    - Same service area for all products
- **This may serve to limit the product choices and carrier choices available to state employees in some areas**

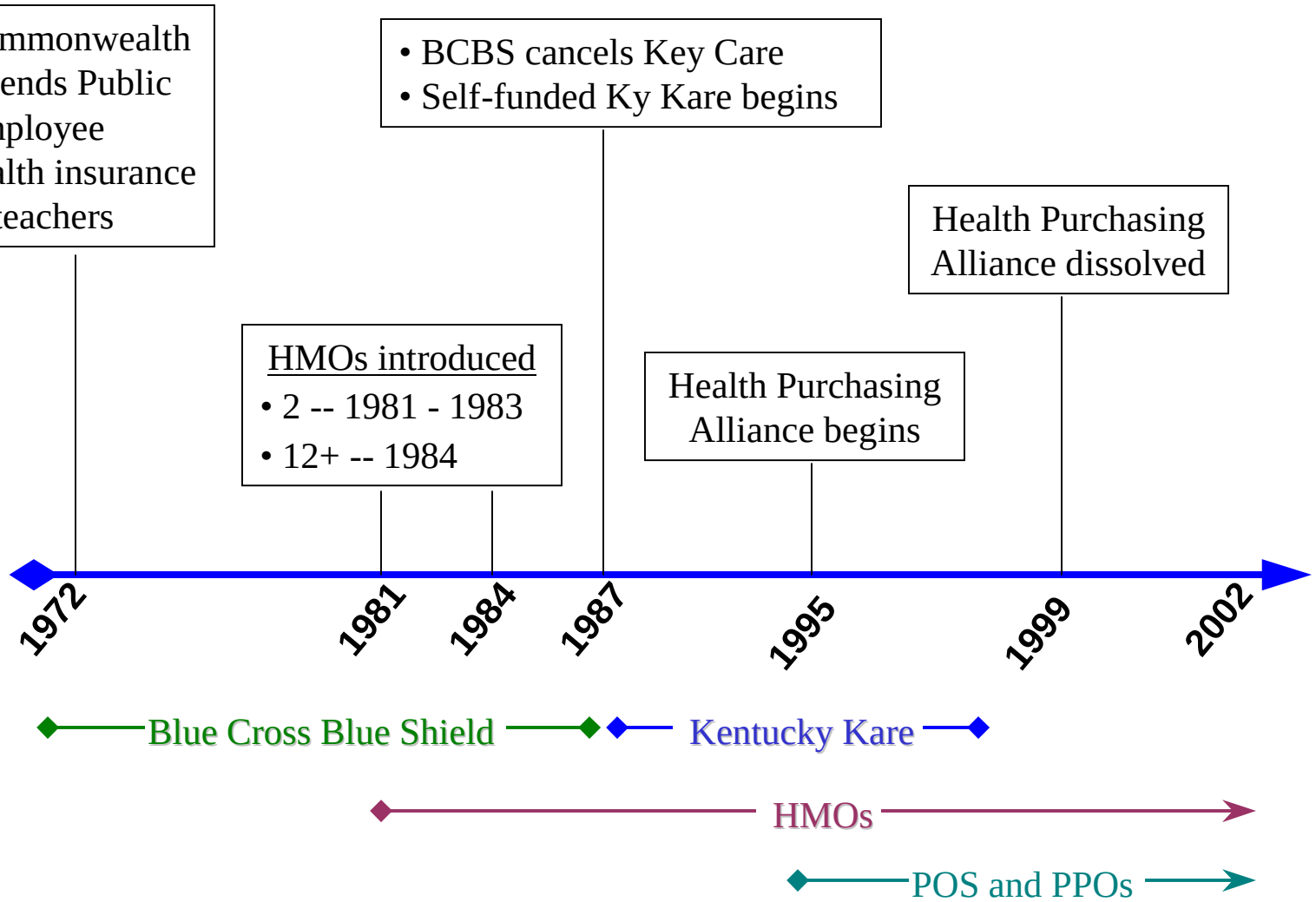
Break

Secretary Palmore

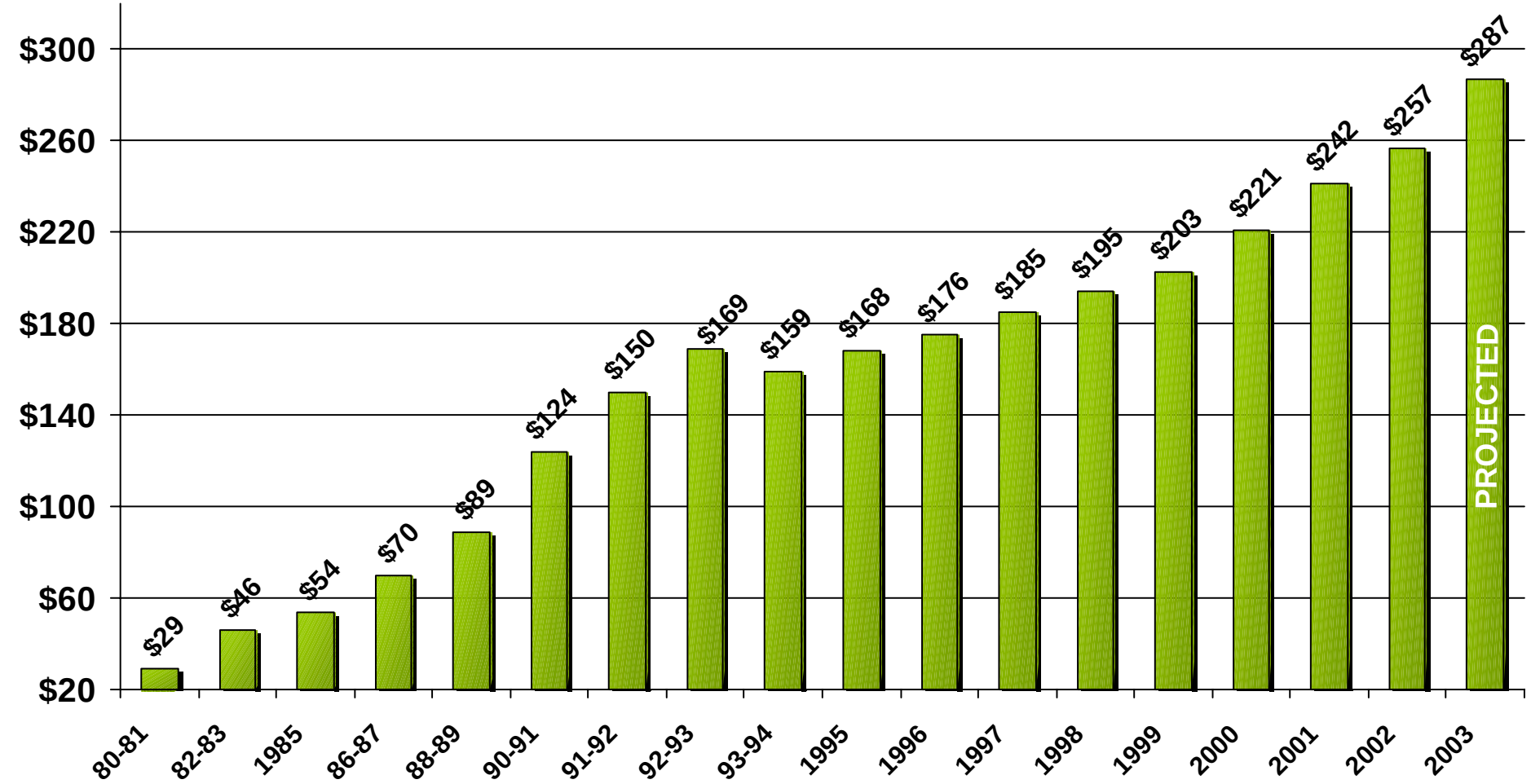
The Public Employee Health Insurance Program

- History
- Historical State Contribution
- Program Milestones
- 2001 Board Recommendations
- 2003 RFP
- Dependent Subsidies
- Major Issues

Public Employee Health Insurance Program History



Historical Commonwealth Health Insurance Contribution



Total Projected Commonwealth Cost in 2003: $588,217,082

Milestones

- **2000**
  - Legislation creates the Kentucky Group Health Insurance Board.
  - Data Analysis Branch created.

- **2001**
  - MedStat on-line. Data available to the Commonwealth by mid-year.
  - OPEHI releases its first annual report in June to the General Assembly.
  - The KY Group Health Insurance Board releases its first report to the Kentucky General Assembly.

2001 Board Recommendations

Recommendation	Resolution/Status
Pay full cost of single lowest cost Option A.	Policy still in effect.
Provide healthcare FSA to those who waive coverage at level currently in effect.	Policy still in effect.
Provide only one healthcare contribution to each individual eligible for Commonwealth Group health insurance.	HB 846 enacted by the 2002 General Assembly tightens “double dipping” exclusion.
Recoup forfeitures from healthcare FSAs from all entities in Commonwealth Group.	Language exists in KRS 18A.225(2)(g).
Subsidize cost of dependent health insurance premiums, to the extent financially feasible while maintaining no employee contribution for single lowest cost Option A.	Due to budgetary constraints and high health insurance trends, it is not currently feasible for the Commonwealth to implement explicit dependent health insurance premium subsidies. Implicit subsidies from relationship between single and dependent premiums rates are still in effect.

2001 Board Recommendations cont.

Recommendation	Resolution/Status
Maintain current level of benefits, to the extent possible. Otherwise, modify over time to stay in line with other states' programs.	2002 benefit provisions essentially same as those in effect in 2001
Implement mail order pharmacy feature.	HB 369 was passed by General Assembly
Investigate other pharmacy initiatives to obtain the most cost effective prescription drug benefits possible: ▪ purchasing pools ▪ co-pay/co-insurance structure ▪ other	The Commonwealth's carriers continue to adjust prior authorization, step therapy and quantity limit guidelines. Purchasing pools are more feasible under self-funded arrangements. Alternative benefit structures may be considered in future years.

2001 Board Recommendations cont.

Recommendation	Resolution/Status
Maintain prescribed premium rate relationship between Single, Couple, Parent+ and Family coverage levels and A and B options.	Policy still in effect.
Require all health insurers to offer a given option at the same price statewide and to allow out-of-state retirees to participate in options with out-of-network benefits.	Policy still in effect.
Require active employees of all entities whose retirees participate in the Commonwealth Group program to also participate. or Require those entities to be responsible for the actuarial difference in cost of their retirees.	HB 846 enacted by the 2002 General Assembly requires the Interim Joint Committee on State Government to determine the cost to members of the Commonwealth Group of allowing retirees to participate in the Commonwealth program without their corresponding actives. The LRC is to hire an actuary, with no contractual relation with OPEHI, KEA, KACO, any state retirement system or any entity affected, to assist with study. The report due on or before October 1, 2002 is to include a 5-year projection and recommended administrative procedures.

2001 Board Recommendations cont.

Recommendation	Resolution/Status
Restrict Commonwealth Group membership to public employees and retirees.	HB 846 enacted by the 2002 General Assembly clarifies the Commonwealth Group's eligibility definition, consistent with the Board's recommendation. It also specifies that the contribution from participating entities must be at least equal to the state's contribution rate.
Statutorily limit the ability of entities to enter and exit the Commonwealth Group.	HB 846 enacted by the 2002 General Assembly clarifies that the state-funded contribution ends if an entity terminates participation of its active employees from the Commonwealth Group.
Do not risk adjust the premiums paid to the Commonwealth Group's insurers.	Risk adjustment has not been implemented.

2001 Board Recommendations cont.

Recommendation	Resolution/Status
Only self-fund the Public Employee Health Insurance Program if it is highly likely to result in substantial cost savings. and Consider the impact on the overall Kentucky health insurance market if the Commonwealth self-funds the Public Employee Health Insurance Program.	SCR 34 adopted by the 2002 General Assembly directs the Interim Joint Committee on Banking and Insurance to study the feasibility of self-funding at least one health insurance option for state employees. Findings are due to the LRC no later than December 1, 2002. 2003 RFP requested self-funded, as well as insured, bids.

2001 Board Recommendations cont.

Recommendation	Resolution/Status
Establish a permanent Board and include legislative and judicial representatives.	HB 163 enacted by the 2002 General Assembly expands the Kentucky Group Health Insurance Board, to include: ▪ Director of the Administrative Office of the Courts ▪ KRS retiree ▪ KTRS retiree ▪ Active teacher ▪ Active state employee ▪ Active classified education support employee HB 846 enacted by the 2002 General Assembly expands the Advisory Committee from 28 to 32 members, to include: ▪ Two members from the Kentucky Association of Counties ▪ Two members from the Kentucky League of Cities

Health Insurance 2003 RFP

- Initial work began in Dec 2001 by reviewing prior plan year issues
- Draft document prepared – Jan 2002 to Mar 2002
- RFP was released April 5, 2002
- Incorporated all statutory changes – April 26,2002
- Responses received - May 6, 2002
- Review Teams Evaluated - May 7th - May 29th
- Presented to Evaluation Committee - May 29th - June 5th
- Contracts Signed - 7/22 - 7/26

Health Insurance 2003 RFP

Requested Bid Scenarios

Scenario 1

- Fully insured
- Single statewide carrier offering PPO (Option A and Option B) and EPO.
- Additionally, multiple carriers (up to 2 additional per county) offering HMO and POS Option A.
  - Bids for entire Medicaid regions and a minimum of 50 counties.
  - 50 county minimum to prevent “cherry picking” the Louisville and/or Lexington regions and leaving the rest of the Commonwealth without an HMO or POS

Scenario 2

- Self insured
- Single vendor statewide PPO (Option A and B) and EPO.
- Additionally, the selected vendor could have offered an HMO in any county.

Scenario 3

- “Current Plan” – Fully insured, up to 3 carriers per county.

Carrier Availability

	2002	2003
3 Carrier Counties	71	24
2 Carrier Counties	34	48
1 Carrier Counties	15	48

Commonwealth's Cost for Dependent Subsidies

Dependent Subsidy Cost Estimates	
Dependent Subsidy	**Estimated 2001 Commonwealth Cost** *(in millions)*
25%	$ 37.5
50%	$119.8
70%	$202.4
80%	$274.2
90%	$365.5
100%	$445.9

Source: October 2001 Report

Major Issues

- Cost
- Availability
- Dependent Subsidy
- Funding Adequacy
- Self-Insurance
- Flexible Spending Accounts

Health Plans Today

- **Other States**
- **Large Employers**

Barbara Alvey, CEBS

Mercer Human Resource Consulting, Inc.

Summary Comparison to Other States
2001 Commonwealth Survey

	Kentucky	Other States
Groups Covered		
➢ Teachers/Health boards	Yes	42%
➢ Universities	Regional – retirees only	71%
➢ Local governments	Retirees – Yes Actives – Optional	24%
Allocation of Health Insurance Funding		
➢ Employee coverage	100%	88%
➢ Dependent coverage	0%	66%
➢ Waivers	$234	$0
Funding Arrangement		
➢ HMO	Insured	88% Insured
➢ PPO	Insured	56% Self-Funded
Pre-65 Retiree		
➢ Contribution	Same as actives *(if 20+ years service)*	Same as actives: 21% Retiree pays all: 21% Service based : 28% Other : 30%
➢ % of Group	20%	9%

Source: Commonwealth of Kentucky 2001 survey

States' Plan Provisions - 2001

	HMO		PPO In-Network	
	Other States	Kentucky Option A	Other States	Kentucky Option A
Annual deductible	N/A	N/A	$225	$250
Hospital inpatient	$0	$100	10%	20%
Outpatient surgery	$0	$50	10%	20%
Physician office	$10	$10	$10 or 10%	$10
Rx – retail				
Generic	$7	$10	$6	$10
Brand	$15	$15	$15	$15
Non Formulary	$25*	$30	$30**	$30
Annual OOP max	Unlimited	$1,000	$1,000	$1,250

*** 44% reported a 3-tier co-pay**
**** 52% reported a 3-tier co-pay**

Source: Commonwealth of Kentucky 2001 survey

States' 2001 Average Monthly Contributions

	Survey Averages (unweighted)			
	Employee	Parent+	Couple	Family
Employer	$225	$399	$416	$491
Employee	$34	$104	$130	$155
Employee Contribution %	13%	25%	24%	24%

NOTE: Reflects average of all plans reported - in some cases employee contributions were provided but not total cost.

	Commonwealth of Kentucky – 2001 Option A*			
	Employee	Parent+	Couple	Family
Employer	$241	$241	$241	$241
Employee	$22	$154	$346	$408
Employee Contribution %	8%	39%	59%	63%

* Weighted average of plans Commonwealth Group members actually selected, not lowest cost Option A available to them. The Commonwealth pays 100% of the cost of single coverage under the lowest cost Option A.

Source: Commonwealth of Kentucky 2001 survey

Pre-65 Retiree Health Insurance - Other States

Eligibility Requirements - 2002 Survey

Minimum Requirement	Percentage of States
No age or yrs min.	3.85%
5 / Any	3.85%
5 / 55	15.38%
5 / 60	7.69%
5 / 62	3.85%
8 / 60	3.85%
8 / Any	3.85%
10 / Any	3.85%
10 / 55	19.23%
10 / 60	15.38%
10 / 62	3.85%
20 / 55	3.85%
20 / 62	3.85%
30 / Any	3.85%
Age + yrs = 80	3.85%

Source: Internet and telephone survey conducted by Mercer in September 2002

Pre-65 Retiree Health Insurance - Other States

Contributions at 20 Years Service - 2002 Survey

	Retiree Premium	Dependent Portion of Premium
No State Contribution	9	12
Shared	8	7
State Pays Full Premium	10	8
Average % Paid by State	56%	45%
Average Monthly Retiree Contribution	$125	$296 *(couple coverage)*

Source: Internet and telephone survey conducted by Mercer in September 2002

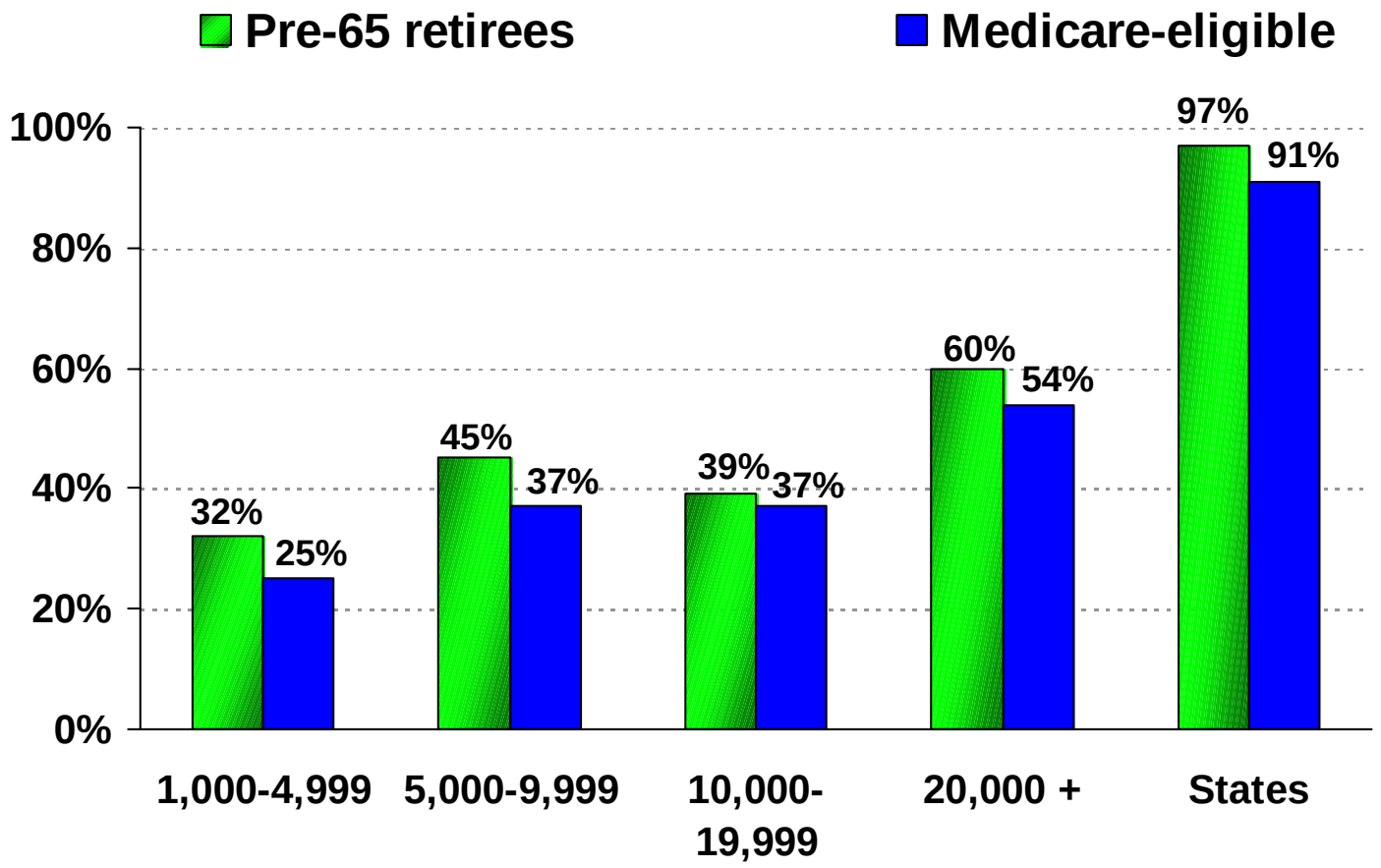
Large Employers

	HMO			PPO In-Network		
	2001 National Employers*	2001 – 2002 Kentucky Employers**	Kentucky 2002 Option A	2001 National Employers*	2001 - 2002 Kentucky Employers**	Kentucky 2002 Option A
Annual deductible	N/A	N/A	N/A	$250	$200	$250
Hospital inpatient	$ 0	$100 or 0%	$100	10%	10%	20%
Physician office	$11	$10	$10	$15	$10	$10
Rx – retail						
Generic	$ 9	$ 7	$10	$ 9	$ 7	$10
Brand	$17	$15	$15	$17	$14	$15
Non Formulary	$31	$25	$30	$31	$24	$30
Annual out-of-pocket max	*Not available*	Unlimited	$1,000	$1,300	$1,000	$1,250
Employee Contributions	*Average*	*Average*	*Weighted Average*	*Average*	*Average*	*Weighted Average*
Employee	$ 47	$ 51	$ 38	$ 56	$ 36	$ 4
Family	$172	$189	$475	$191	$145	$406
Self Fund	13%	86%	No	67%	88%	No

**** Source: 2001 Mercer/Foster Higgins National Survey - Employers with 500 or more employees***

***** Source: Mercer client database***

2001 National Survey - Retiree Health Coverage



Source: 2001 Mercer/Foster Higgins National Survey

Summary Comparison to Large Employers

	Large Employers*	Large Kentucky Employers**	Commonwealth of Kentucky
Allocation of Health Insurance Funding			
➢ Employee coverage	81%	83%	100% of Option A
➢ Dependent coverage	62%	72%	0%
➢ Waivers	–	20% provide $63 average	$234 FSA
Funding Arrangement			
➢ HMO	87% insured	86% self-funded	Insured
➢ PPO	67% self-funded	88% self-funded	Insured
Retiree Healthcare			
➢ Offered – pre-65	29%	80%	Yes
➢ Medicare eligible	23%	40%	Yes
➢ Pre-65 Contributions – Retiree			
– Employer 100%	20%	0%	Yes
– Retiree 100%	35%	25%	No
– Shared	45%	75%	No

**** Source: 2001 Mercer/Foster Higgins National Survey - Employers with 500 or more employees***

***** Source: Mercer client database***

Healthcare Challenges in the Millennium

- How bad is the health care cost situation?
- Why are health care costs going up nationally?
- What strategies are employers and states using to help control spiraling costs?

Trudi Matthews
Chief Health Policy Analyst
The Council of State Governments

So tell me, doctor, how bad is it?

How bad is it? Part 1:

According to latest data,

- 2001 health spending growth = 10%
- 1st double digit increases in over a decade
- 2.2% higher than 2000
- 5th year of growth higher than year prior

Source: Strunk, Ginsburg, Gabel, "Tracking Health Care Costs: Growth Accelerates Again in 2001," **Health Affairs,** *September 25, 2002 –* www.healthaffairs.org

% Change Per Capita in Health Care Spending *1991-2002*

	All Services	Hospital Inpatient	Hospital Outpatient	Physician Services	Prescription Drugs	GDP Growth
1991	6.9	3.5	16.8	5.4	12.4	1.8
1992	6.6	2.8	13.9	5.9	11.7	4.2
1993	5.0	4.8	8.9	3.3	7.1	3.8
1994	2.1	-2.0	8.7	1.7	5.2	4.9
1995	2.2	-3.5	7.9	1.9	10.6	3.7
1996	2.0	-4.4	7.7	1.6	11.0	4.4
1997	3.3	-5.3	9.5	3.4	11.5	5.2
1998	5.3	-0.2	7.5	4.7	14.1	4.3
1999	7.1	1.6	10.2	5.0	18.4	4.4
2000	7.8	2.5	11.5	6.3	14.5	4.7
2001	10.0	7.1	16.3	6.7	13.8	1.4
2002*	8.8	6.2	13.6	5.7	13.0	1.8

*** = projected; Source: *Health Affairs*, September 25, 2002, www.healthaffairs.org**

How bad is it? Part 2:

But it is even worse with insurance premiums,

- 2001 health insurance premium growth = 12.7%
- Largest increase since 1990
- 6th year of growth higher than year prior
- Employer costs projected to rise 13-16%
- Employers also scaling back benefits = actual costs would be higher if benefits the same (~ 15%)

Source: Strunk, Ginsburg, Gabel, "Tracking Health Care Costs: Growth Accelerates Again in 2001," Health Affairs,*September 25, 2002 – www.healthaffairs.org; Also Hewitt Associates data, Cincinnati Enquirer, 9/20/02*

But the real question is: WHY?

Why are health costs increasing?

Are we…

- Older and Sicker? *(aging population)*
- Using more services? *(utilization)*
- Using more *expensive* services? *(technology)*
- Paying more? *(inflation)*
- Or some combination of all of the above?

And the answer is…

All of the above and more!

- **Hospital costs:**
  - **Growth in use of services (utilization +)**
    - Accounted for most of hospital cost increase
    - BACKLASH AGAINST MANAGED CARE
  - **Higher hospital rates (paying more)**
    - Tougher negotiations with health insurers
    - Labor shortages *(particularly nurses)*
    - BBA cost shifting

Source: Strunk, Ginsburg, Gabel, **Health Affairs,** ***September 25, 2002***

And the answer is…

All of the above and more!

- **Prescription Drugs:**
  - Using more (utilization +)
  - Using newer, more expensive (technology)
  - Price increases (inflation)
    - Price is just a small piece of the increase, mostly usage
- **Physician Services: Smallest growth**
  - Using more (utilization +)
  - Payment rates increasing
    - Backlash against managed care again

Sources: Dubois, Chawla, et. al., "Explaining Drug Spending Trends," **Health Affairs,** ***March/April 2000; Strunk, Ginsburg, Gabel,*** **Health Affairs,** ***September 25, 2002***

Surprise, Surprise, Surprise

- Hospital costs largest driver of health costs = hurts more than drugs because it's a bigger piece of the pie

  inpatient and outpatient cost = more than 50% of increase nationally

- Aging is NOT responsible for significant portion of increasing costs *(only 0.7 %)*
- Early indications are that costs may have peaked -**Next year may be a little better!** *(But not much)*

Why are health insurance premiums increasing?

- Just a reflection of health cost increases?

- OR –

- Are health plans increasing their profits?

- **Or some combination of both of the above?**

And the answer is . . .

Both of the above

Premiums increased 12.7% nationally versus 10% increase in cost, so

- **Rising health care costs account for lions share of premium increases**
- **BUT, the actuarial cycle also plays a role**
  - Premiums rising faster than health care costs
  - Profits growing faster than expected for health insurance industry

% Change in Employer-Based Health Premiums *1991-2002*

	Large Firm Premiums	All Firm Premiums	Health Care Spending
1991	11.5	-	6.9
1992	10.9	-	6.6
1993	8.0	8.5	5.0
1994	4.8	-	2.1
1995	2.1	2.3	2.2
1996	0.5	0.8	2.0
1997	2.1	-	3.3
1998	3.3	3.7	5.3
1999	4.1	4.8	7.1
2000	7.5	8.3	7.8
2001	10.2	11.0	10.0
2002*	12.5	12.7	8.8

So what do we do?

What strategies are employers and states using to help control costs?

We’re out of silver bullets, Tonto!

We’ll just have to make people understand how much health care really costs!

Trends in Employer-Sponsored Insurance

- **Changes in cost-sharing**
  - **Increases in copays, deductibles and coinsurance**
  - **Tiered drug copayments**
  - **Increases in employee share of premiums**

➡ **Most employers using higher deductibles and tiered drug copays to control costs**

Source: "2002 Employer Health Benefits Survey," Kaiser Family Foundation, September 2002

Trends in Employer-Sponsored Insurance (cont.)

- Changes in benefit design
  - Dropping optional coverage (dental, eye)
  - Tiered provider networks & payments (primary vs. specialist care, in & out of network)
  - Use of medical savings accounts and consumer-driven health plans

Trends in Employer-Sponsored Insurance (cont.)

- Other alternatives
  - Disease management programs
  - Self-funding
  - Changing retiree benefits - by increasing cost-sharing, reducing benefits or eliminating
  - Promoting a more competitive insurance market

Surprise, Surprise, Surprise

- Employee share of premium costs has remained about the same
- Employers are NOT shifting to more tightly managed care (HMOs, POS plans)
- Self-funding savings limited by large health cost increases

Break

Secretary Palmore

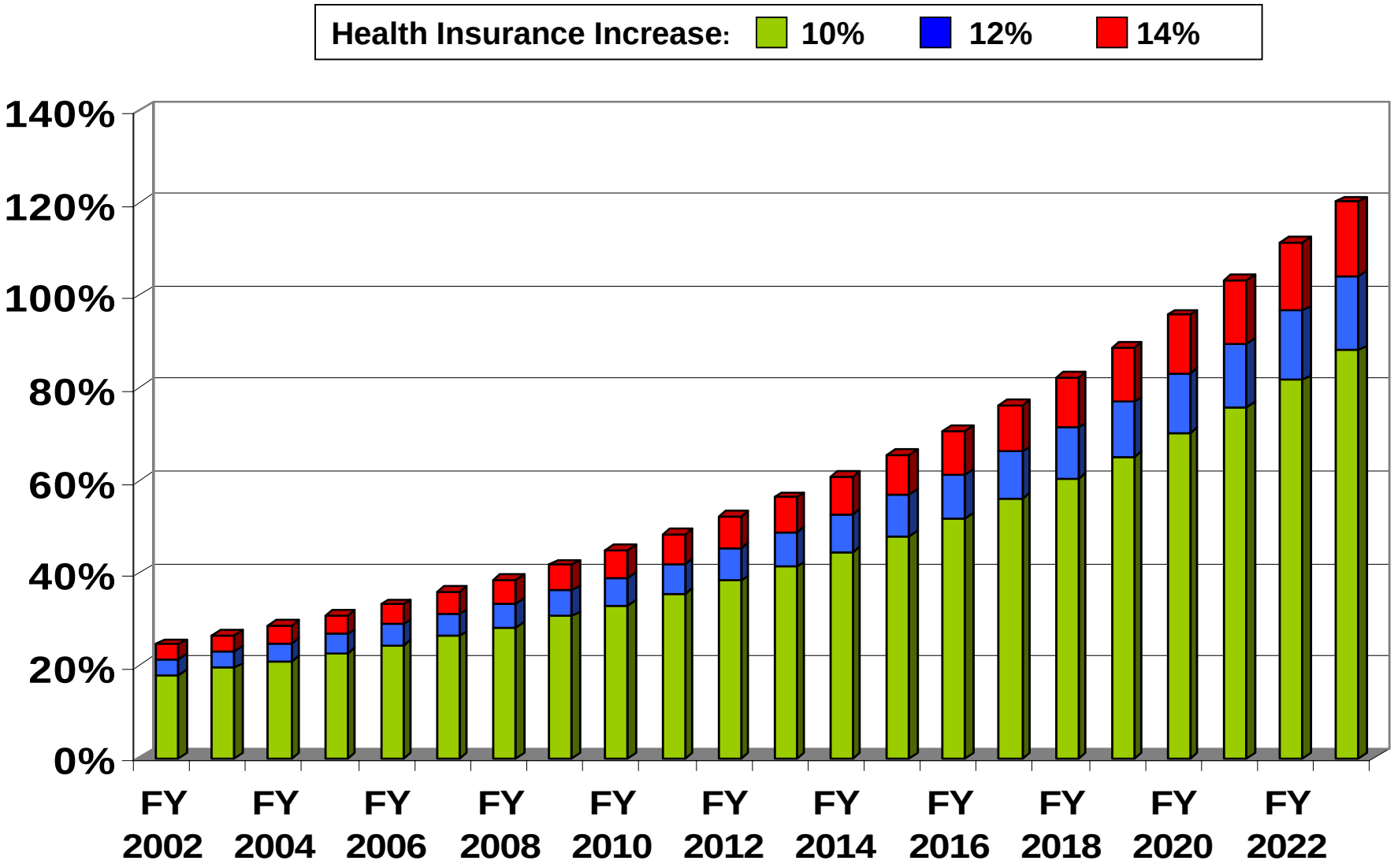
Commonwealth Group: Major Challenges

- Commonwealth Group Trends
- Group Membership
- Aging Population
- Risk Pool Splintering
- Regional Differences
- Allocation of Commonwealth Funds
- Faulty Comparisons

Commonwealth Group Trends

	2000	2001	% Change
Medical Claims	$355,304,194	$400,850,186	12.8%
Rx Claims	$86,411,348	$104,421,366	20.8%
Total	$441,715,543	$505,271,552	14.4%
Premium	$511,369,510	$558,002,180	9.1%
Covered Lives	225,850	225,623	(0.1%)
PMPM Medical	$131.10	$148.05	12.9%
PMPM Rx	$31.88	$38.57	21.0%
PMPM Total	$162.98	$186.62	14.5%
PMPM Premium	$188.68	$206.10	9.2%
Loss Ratio	86.4%	90.5%	

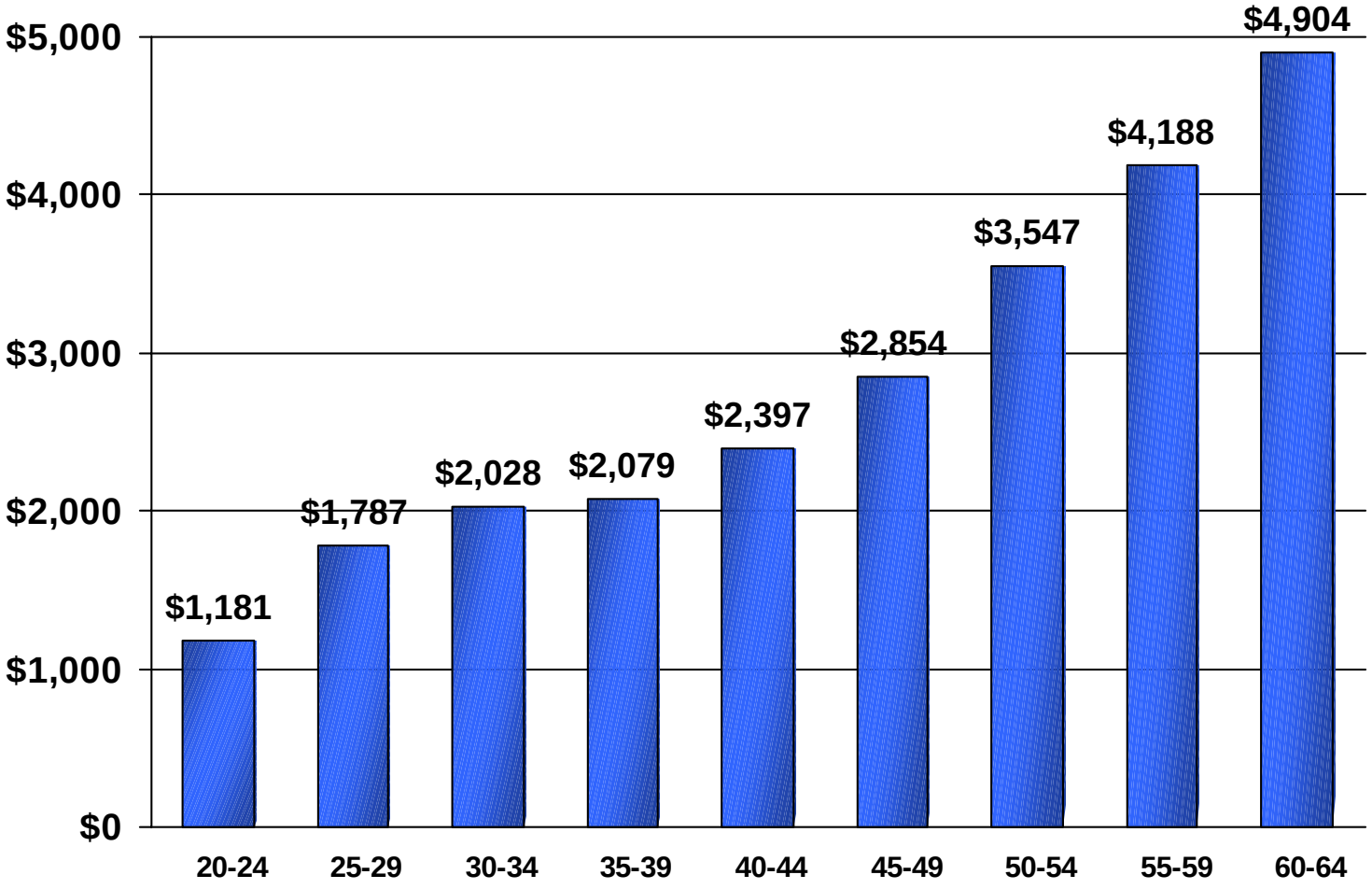
Health Insurance Annual Cost Increase as a Percentage of General Fund Revenue Increase



Commonwealth Group Membership

	1999		2000		% Change	2001		% Change
	Average Lives	% of Total	Average Lives	% of Total		Average Lives	% of Total	
State Employees	61,386	27.0%	60,440	26.8%	(1.5%)	60,218	26.7%	(0.4%)
School Boards	125,188	55.2%	121,781	53.9%	(2.7%)	118,501	52.5%	(2.7%)
Health Depts.	4,562	2.0%	4,241	1.9%	(7.0%)	4,127	1.8%	(2.7%)
KRS	18,097	8.0%	20,389	9.0%	12.7%	22,313	9.9%	9.4%
KTRS	14,330	6.3%	15,368	6.8%	7.2%	16,028	7.1%	4.3%
KCTCS	2,340	1.0%	2,528	1.1%	8.0%	2,968	1.3%	17.4%
COBRA	1,045	.5%	1,104	0.5%	5.6%	1,466	0.6%	32.8%
Total	226,948		225,851			225,621		(0.1%)

Healthcare Costs by Age - Commonwealth Group



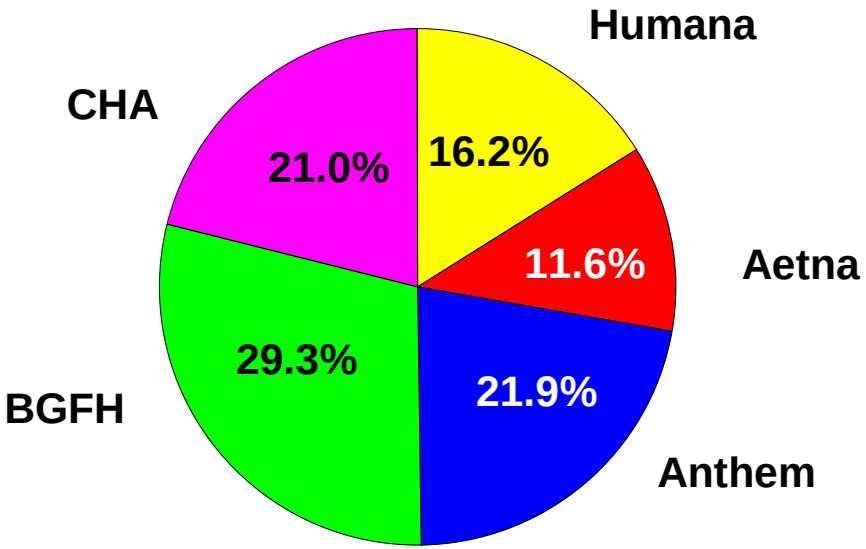
Source: PEHI 2001 allowed charges - 1st quarter 2002 MedStat database

Retirees without Corresponding Actives

- **In 2001, about 7,700 retirees of entities whose actives do not participate in the Public Employee Health Insurance program were covered**
  - **cities, counties, municipalities**
  - **regional universities**
- **Average allowed charges in 2001**
  - **Retirees without actives - $3,930**
  - **All others - $2,476**

Risk Pool Splintering

- **2001**

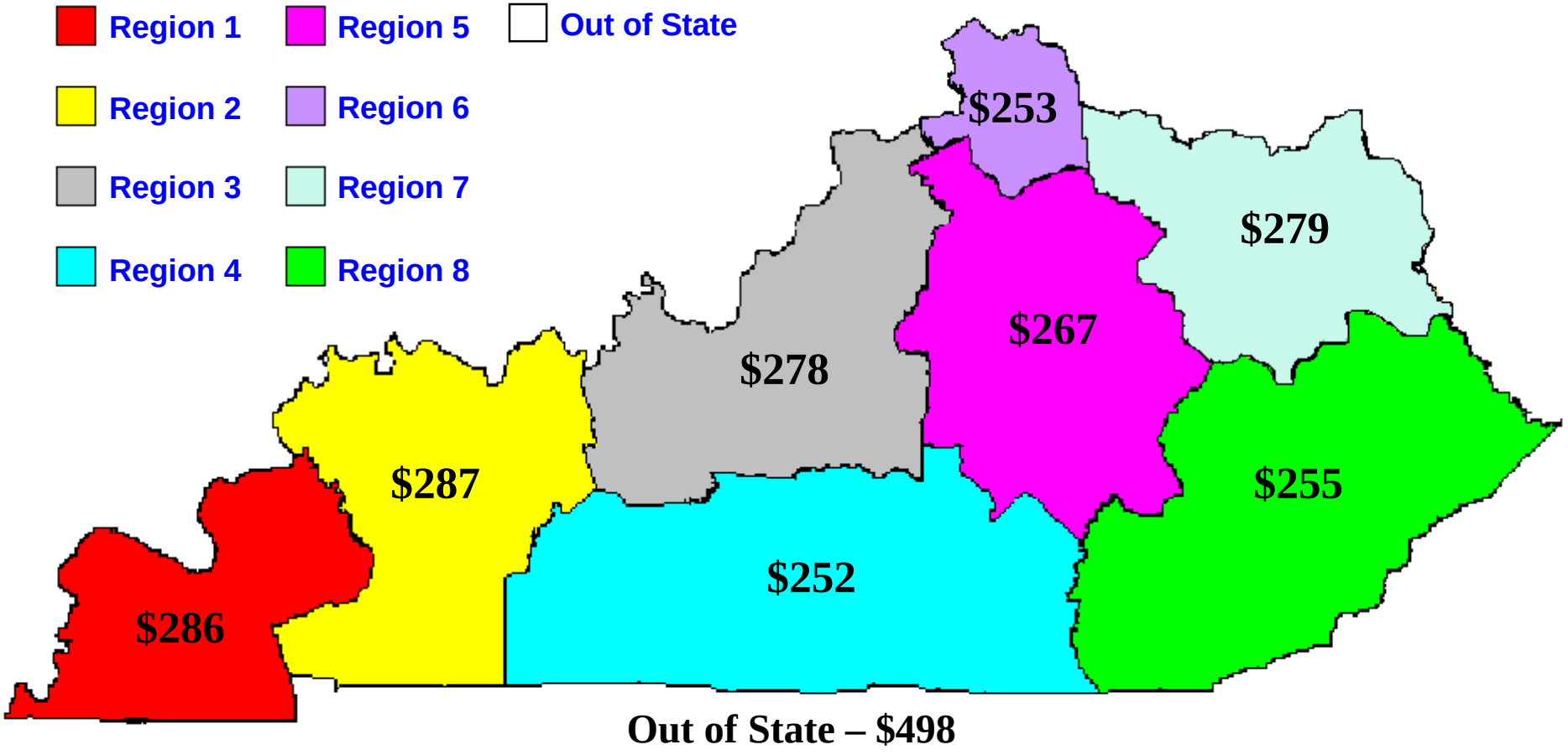


- **Insurers cannot predict enrollment**
  - **Age/gender mix**
  - **Health status**
  - **Geographic area**

Risk Pool Splintering - Impact

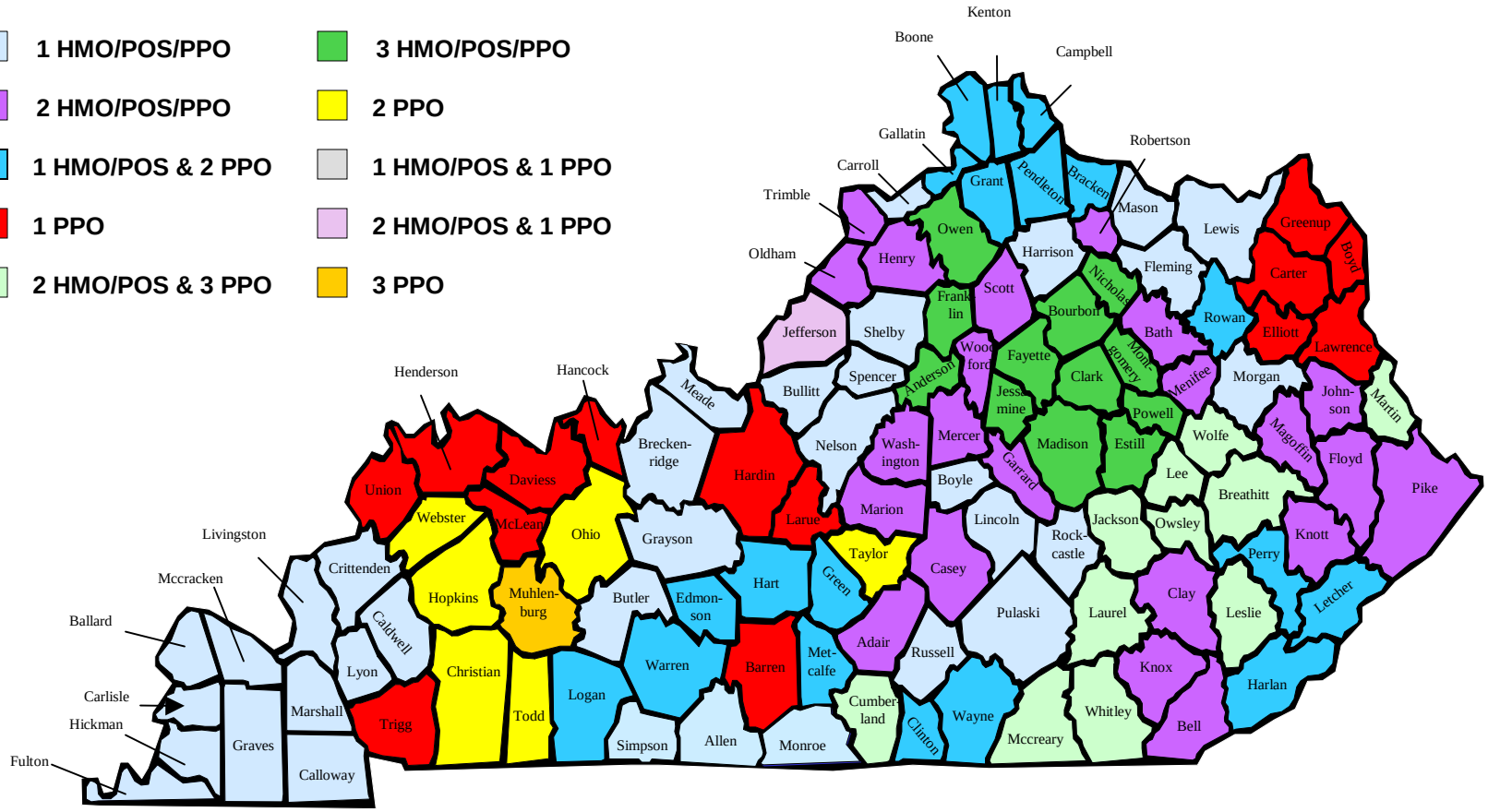
- Higher rates in some geographic areas
- Fewer carriers willing to bid
- Some carriers willing to bid only in select areas
- Impedes health plans' ability to help members manage their health

Regional Differences: 2001 Average Monthly Cost

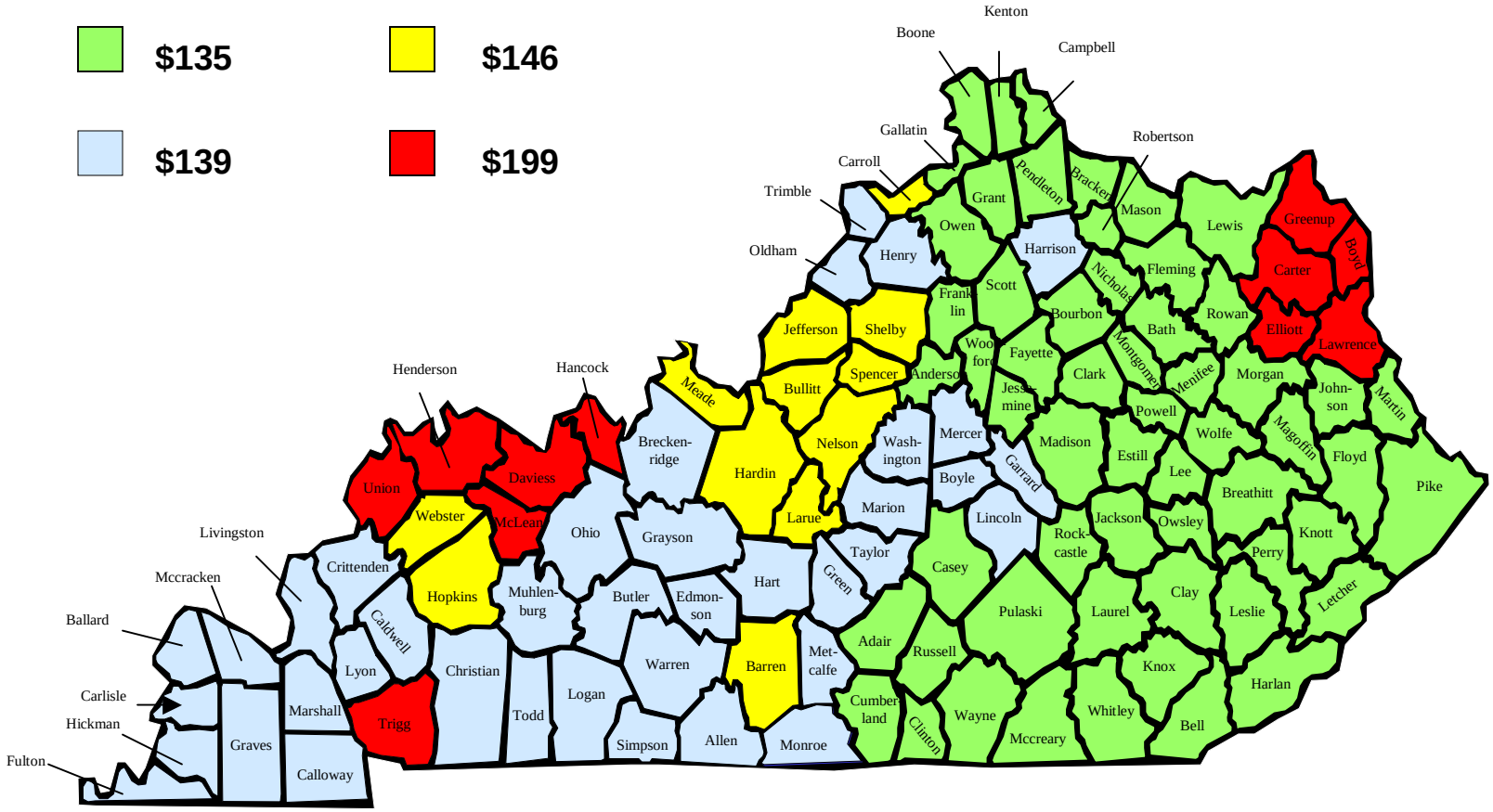


NOTE: Calendar 2001 average allowed charges (total cost) for employees/retirees only

Regional Differences – 2003 Health Plan Options

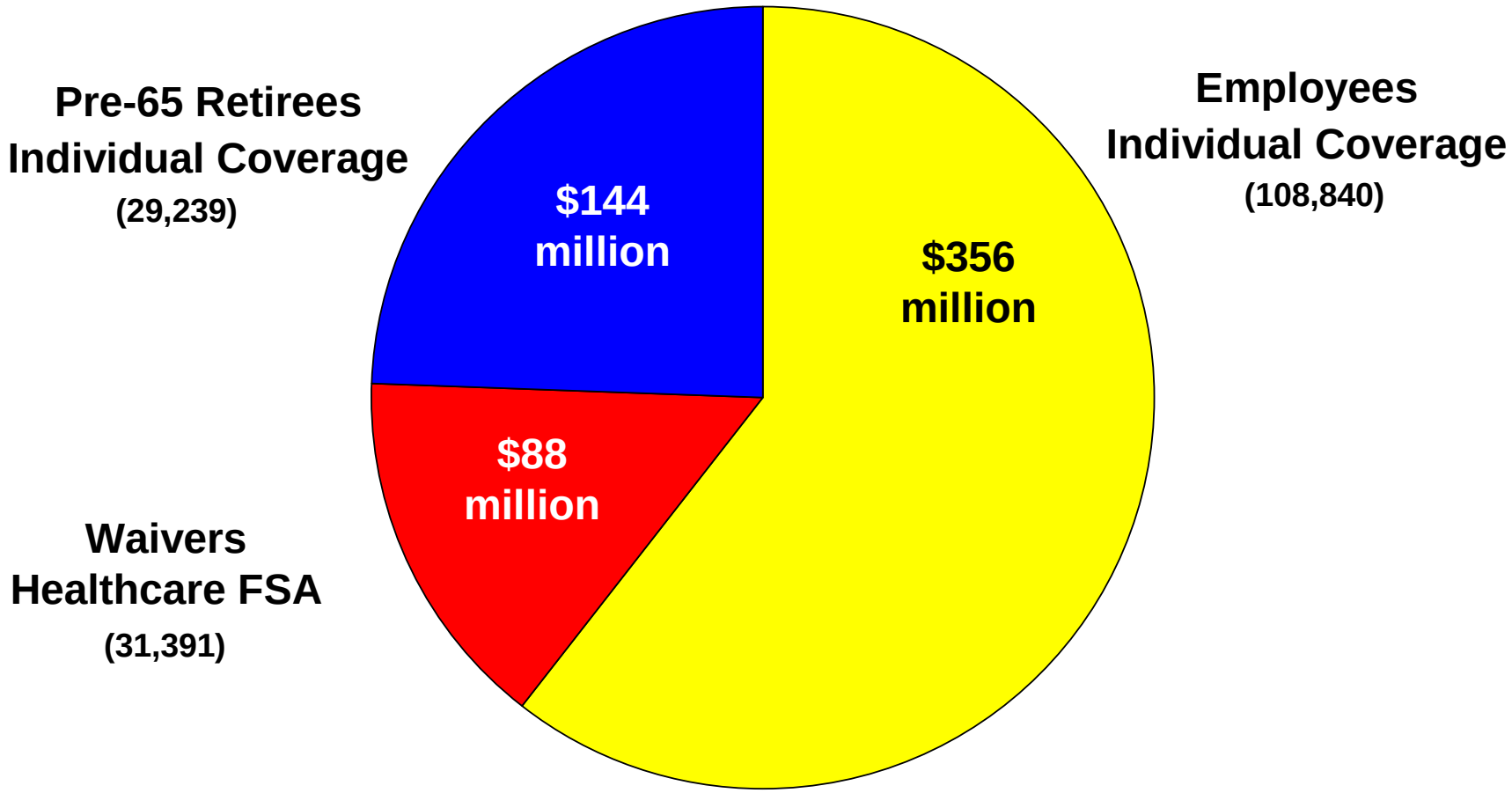


Regional Differences – 2003 Employee Contributions
Lowest Cost PPO A – Parent+ Coverage



Allocation of Commonwealth Funds - 2003

Total Projected Contribution $588 million



Faulty Comparisons: Indiana / Kentucky
Members

- Indiana
  - State employees only
  - Retirees age 55 and 20 years of service and must have 10 continuous years of service immediately prior to retirement
- Kentucky
  - State employees
  - Boards of Education
  - Four State Retirement Systems
  - Technical Schools
  - Health Departments
  - Quasi Agencies
  - Some county and local governmental agencies

Faulty Comparisons: Indiana / Kentucky
Plan Contributions

- Indiana
  - Employees contribute 6% of the cost toward all plans
  - No alternative benefits to health insurance, i.e. FSA
  - Pre-65 retirees pay the total cost for coverage

- Kentucky
  - State pays the full cost of the lowest Option A for all employees/retirees
  - No explicit subsidies for coverage above single

Faulty Comparisons: Indiana / Kentucky
Retiree Population

- Indiana
  - Retirees make up 2.4% of the PPO population
  - Retirees make up 0.3% of the HMO population
  - Retirees must be state agency retirees
- Kentucky
  - Retirees make up 20.7% of the PPO population
  - Retirees make up 17.7% of the HMO population and 29.1% of the POS population
  - Non-state government employees participating in one of the 4 State Retirement Systems are eligible to participate upon retirement

Employee Advisory Council Presentation

Chairman Burtch

Break

Health Insurance in the New Millennium

- Current Environment
- Advanced Approaches in the Private Sector
- State Initiatives

William Craig, MD, MPH
Lew Devendorf

Mercer Human Resource Consulting, Inc.

Traditional Approaches

Plan Design

- Co-pays/deductibles
- Pharmacy benefits

Financing

- Self-funding

Allocation of Commonwealth Funds

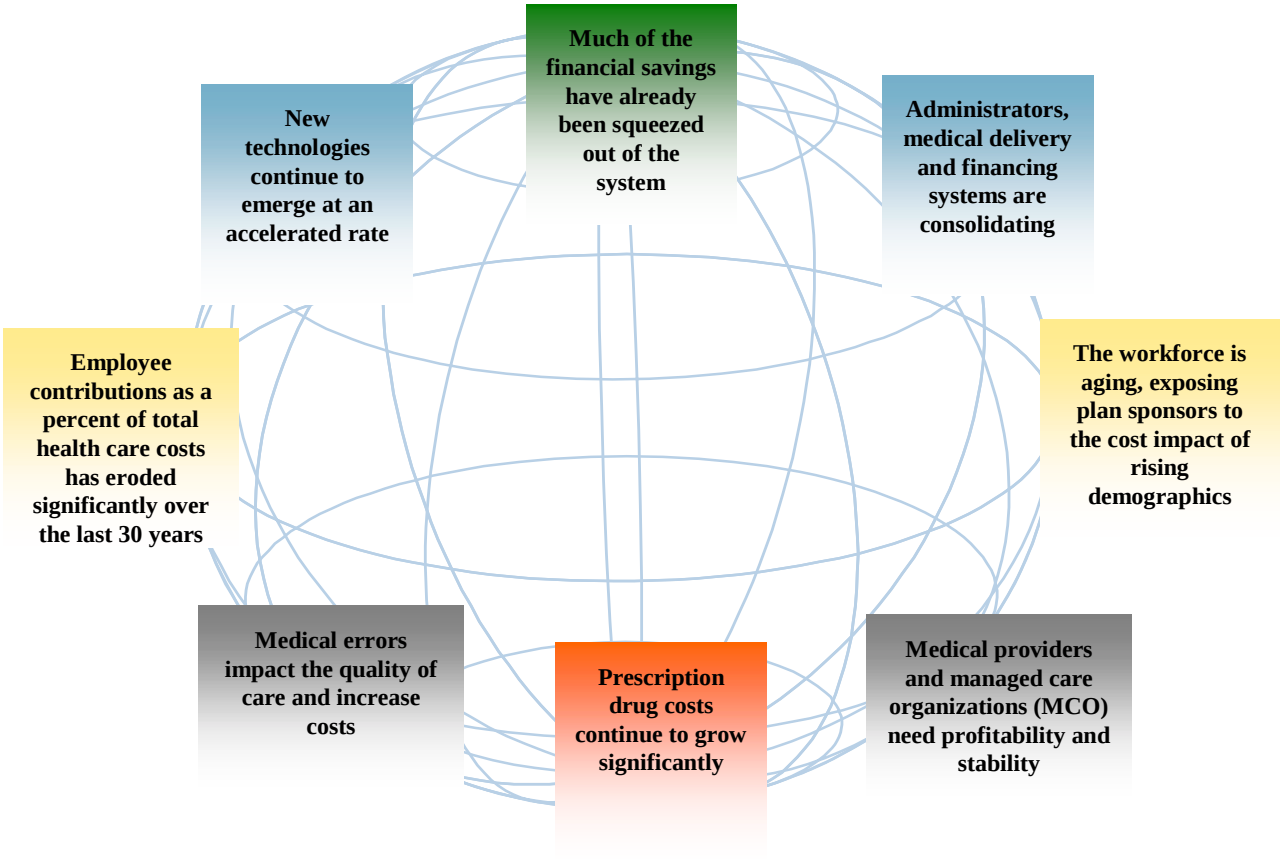
- Healthcare FSA – waivers
- Single coverage
- Retirees

Vendor Management

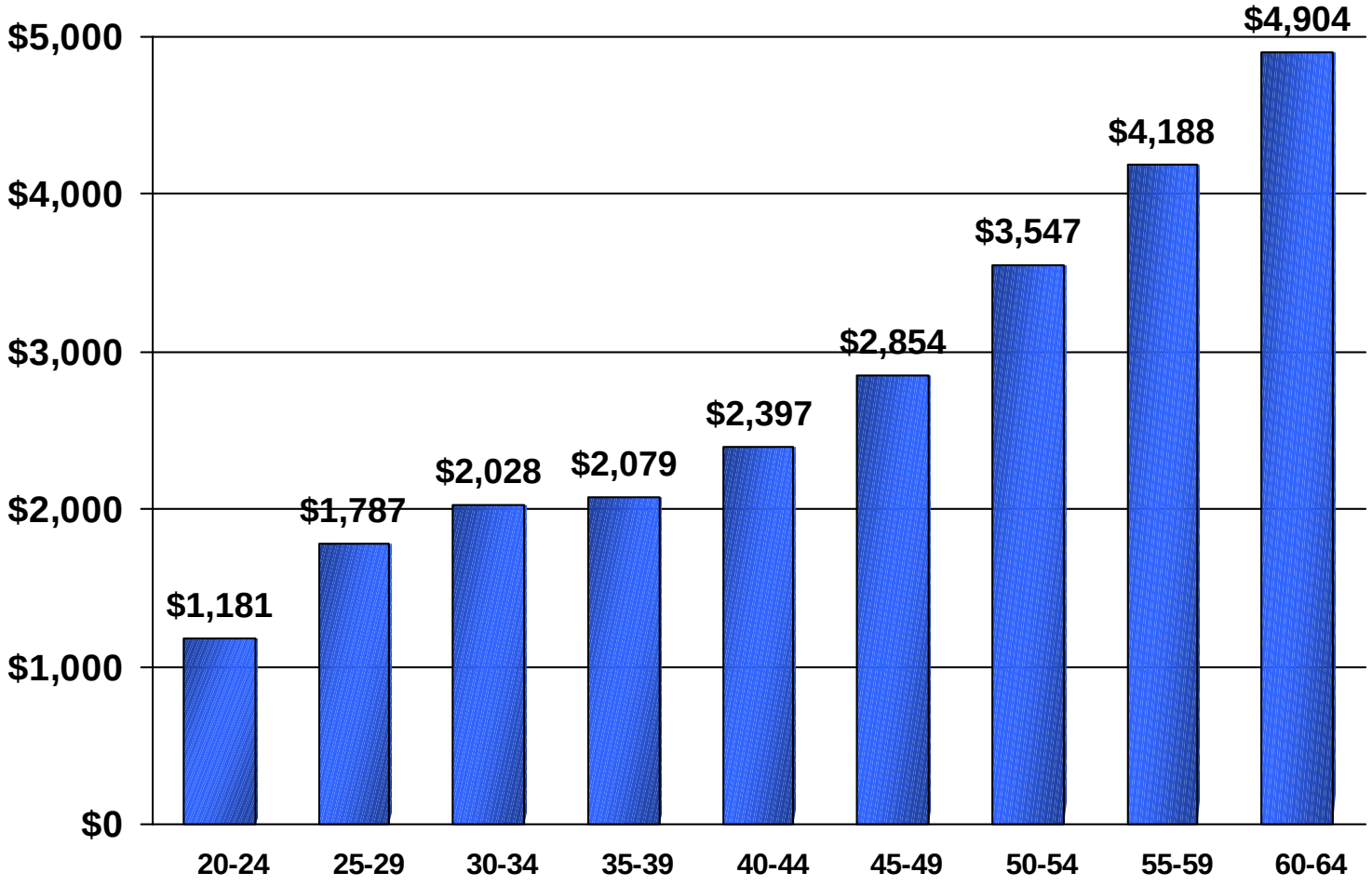
- Performance management
- Network optimization
- Audits

Health Care Marketplace Environment & Trends

Forces converging to produce sustained significant healthcare cost increases



We Talked About the Impact of Age on Cost



Source: PEHI 2001 allowed charges - 1st quarter 2002 MedStat database

...and We're Also Less Healthy

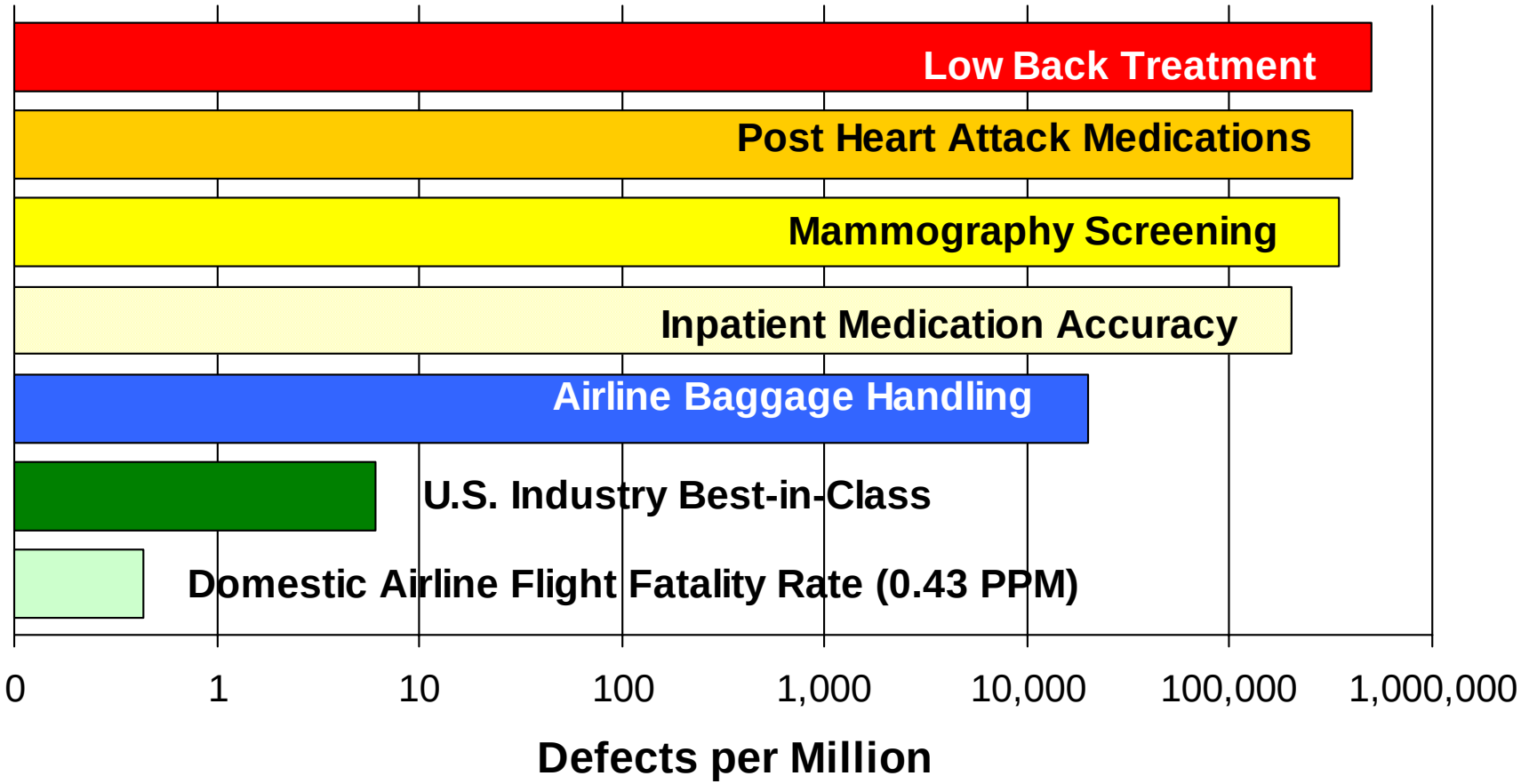
- Lifestyle threats to public's health and well-being include smoking, alcohol and, now, poor eating habits and lack of exercise
- In 2000, health costs attributed to obesity exceeded $117 billion
- 36% of adults are overweight (20 - 30% over ideal weight)
- 23% are obese (> 30% above ideal weight)
- Obesity associated with multiple chronic conditions (diabetes, asthma, heart disease, arthritis)

…and it's More Than Direct Medical Cost

	Average Per Capita Health Cost	Percent of Workers with Condition Missing Workdays	Estimated Work Loss Costs (in billions)	Total Costs for Persons with Condition (in billions
Mood disorders	**$4,328**	**18%**	**$11.5**	**$66.4**
Diabetes	**$5,646**	**10%**	**$3.5**	**$57.6**
Cardiac disease	**$10,823**	**37%**	**$3.8**	**$42.4**
Hypertension	**$4,073**	**8%**	**$11.5**	**$121.8**
Asthma	**$2,779**	**20%**	**$3.4**	**$31.2**

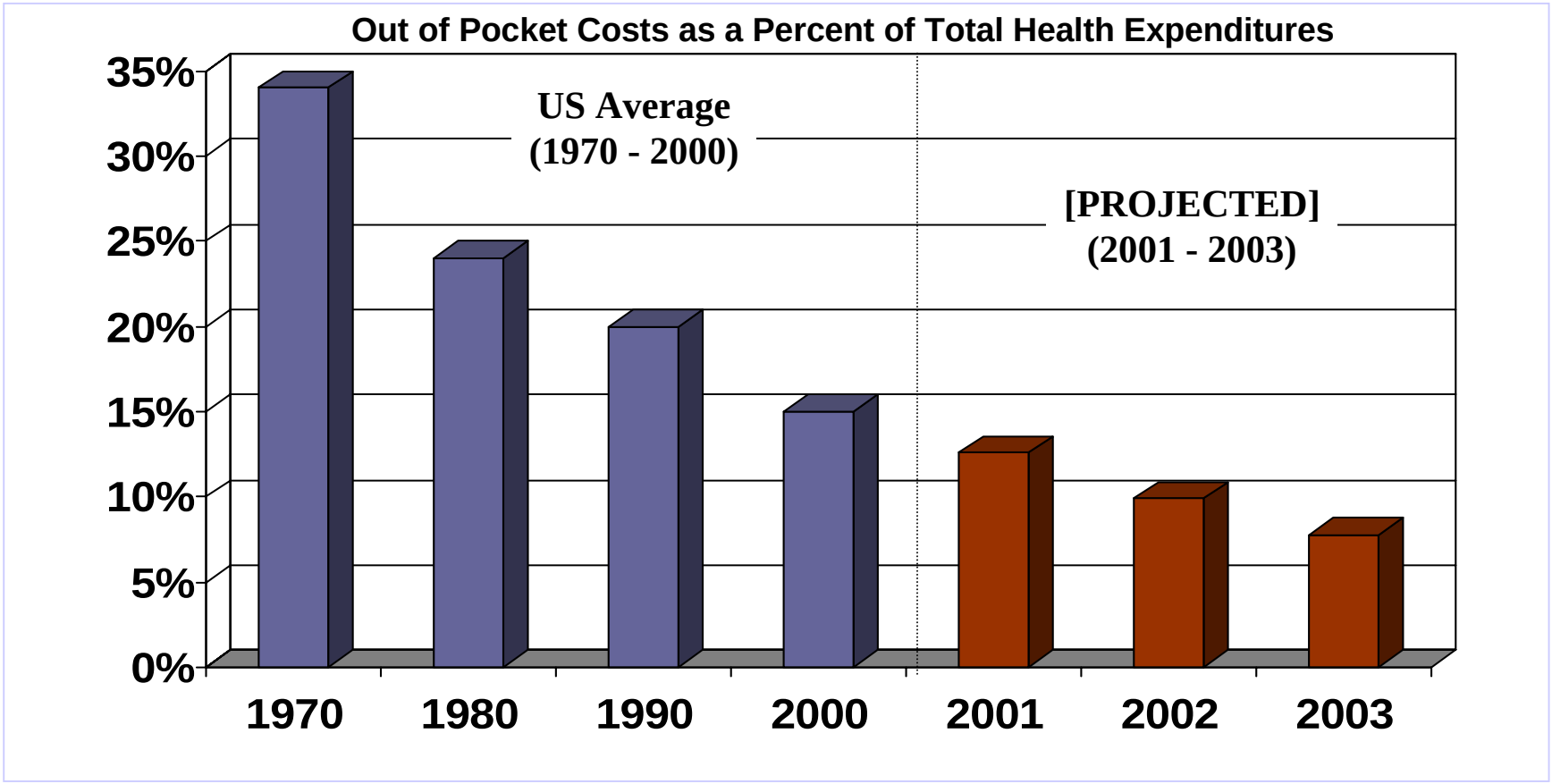
Source: Druss, Marcus, et.al., Health Affairs, Nov/Dec 2001

Healthcare Quality - *"Worse Than Airline Baggage"*



Source: R. Galvin, Integrated Healthcare Report, Sept/Oct 1998

The consumer has become more insulated...



Advanced Approaches in the Private Sector

Manage health care delivery and cost

- Leapfrog
- Collective purchasing
- High-performance networks

Focus on minimizing impact of illness

- Disease management
- Case management

Maintain health

- Health awareness and promotion
- Health risk management

Promote consumer accountability

- Plan design - tiered benefits, stage-of-life plan)
- Education
- Consumer directed health plans

Appropriate Healthcare for Everyone

28% members = 82% cost

Well	At Risk	Acute Illness/ Discretionary Care	Chronic Illness	Catastrophic
No Disease	Obesity High Cholesterol	Doctor Visits Emergency Visits	Diabetes Heart Disease	Head Injury Cancer
– Prevention – Screenings	– Health Risk Assessment – Risk Modeling – Targeted Risk Reduction Programs	– Nurse Advice Line – Web Tools	– Disease Management – Incentive Design – Self Management Training	– Case Management – Decision Support

72% members = 18% cost

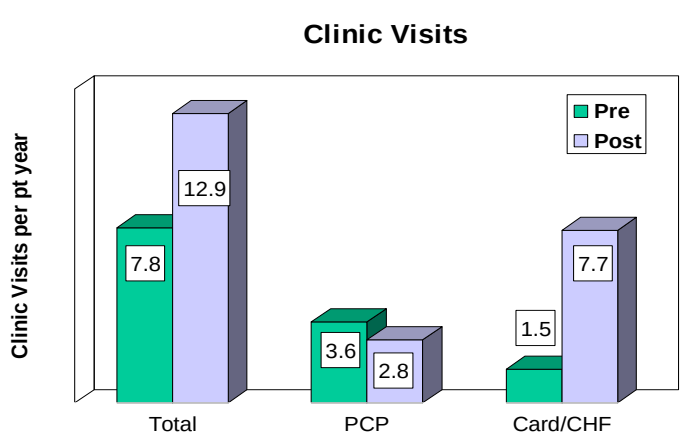
Disease Management Opportunity

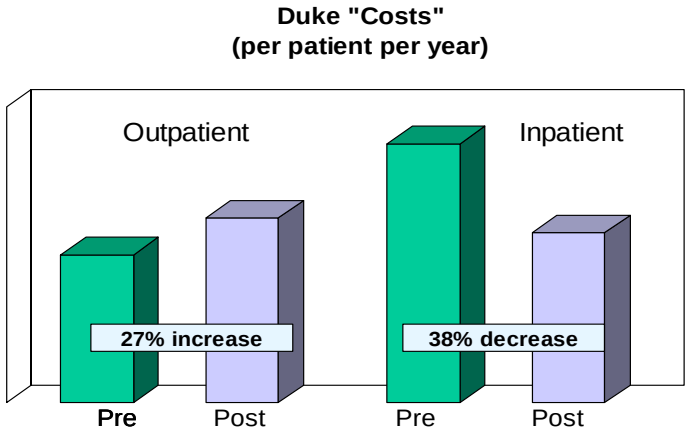
Congestive Heart Failure Example

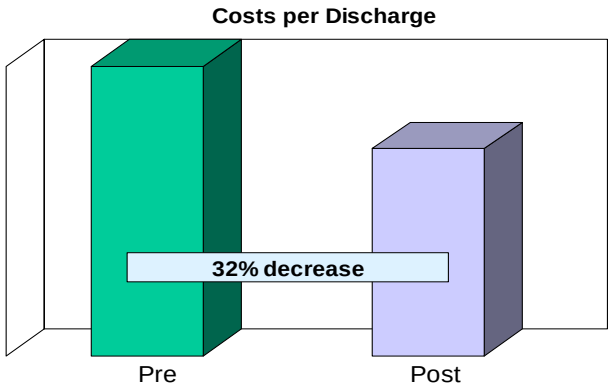
- **Duke congestive heart failure (CHF) disease management**
  - Patient education
  - Focus on medication compliance (ACE inhibitor)
  - Nurse manager available 24/7
  - Regular clinic follow-up
  - Telephone call back to all participants
- **Potential savings per discharge in the Duke model is 32%**

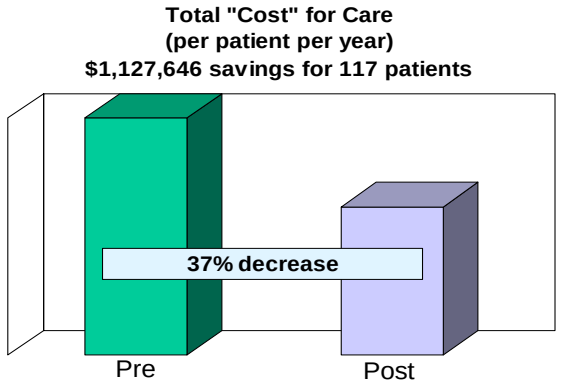
Disease Management Opportunity

Congestive Heart Failure Example









Duke University Medical Center Study

Opportunities to Minimize Illness Impact

- Congestive heart failure?
- Low back pain?
- Diabetes?
- Asthma?

Leapfrog

- **Business Roundtable Launched in 2000**
  - **composed of 100+ public and private organizations**
  - **approximately 32 million health care consumers**
  - **all 50 states**
- **Goal: Improve Patient Safety**
  - **reward hospitals for advances inpatient safety**
  - **educate employees, retirees and families of importance**
- **Three Initial Standards**
  - **Computer Physician Order Entry (CPOE)**
  - **ICU Physician Staffing**
  - **Evidence-Based Hospital Referral**

Research indicates could save 58,300+ lives and prevent 522,000 serious medication errors annually

Source: The Leapfrog Group

Leapfrog Barriers

- **Computer Physician Order Entry**
  - Cost – Bigham and Woman's Hospital
    - implementation – $1.9 million
    - maintenance – $500,000 annually
  - Cultural obstacles
- **Evidence-Based Hospital Referral**
  - Patients– travel in rural areas
  - Low volume hospitals
    - loss of surgical revenue
    - worry about being branded "second class"
  - Physicians – affront to professional judgement
- **ICU Physician Staffing**
  - Small hospitals may lack required economics of scale
  - Shortage of available trained personnel
  - Physicians may be unwilling to relinquish care of patients

Source: The Leapfrog Group

High Performance Networks

- **Specialists control over 70% of medical spend**
- **Efficiency variation between specialists within a community is usually significant –– at least 40%; often triple digits**
- **Growing evidence of correlation between specialist efficiency and quality**
  - Specialists' practice patterns and costs
  - Prescription drugs
  - Lab fees
  - MRI
  - Inpatient/outpatient costs
- **Conclusion**
  - Focus initial efforts on specialists

High Performance Networks

A Case in Point

Situation

- 8,000 lives in Charleston, WV
- National POS plan with very high costs
- 1998 pmpm was $185

Challenge

- Reduce plan costs, but:
  - No compromise on quality
  - No design or vendor changes
  - Cost management, not cost shift
  - No employee unrest

Action

- Extensive analysis to identify variations in specialist efficiency
- Approached PCPs directly (without health plan) to form partnerships to steer care toward more efficient specialists
- 1/3 of savings shared with PCPs

Result

- 15% savings in year 1
- January 2001 pmpm = 2% more than 1998 pmpm
- Zero member complaints

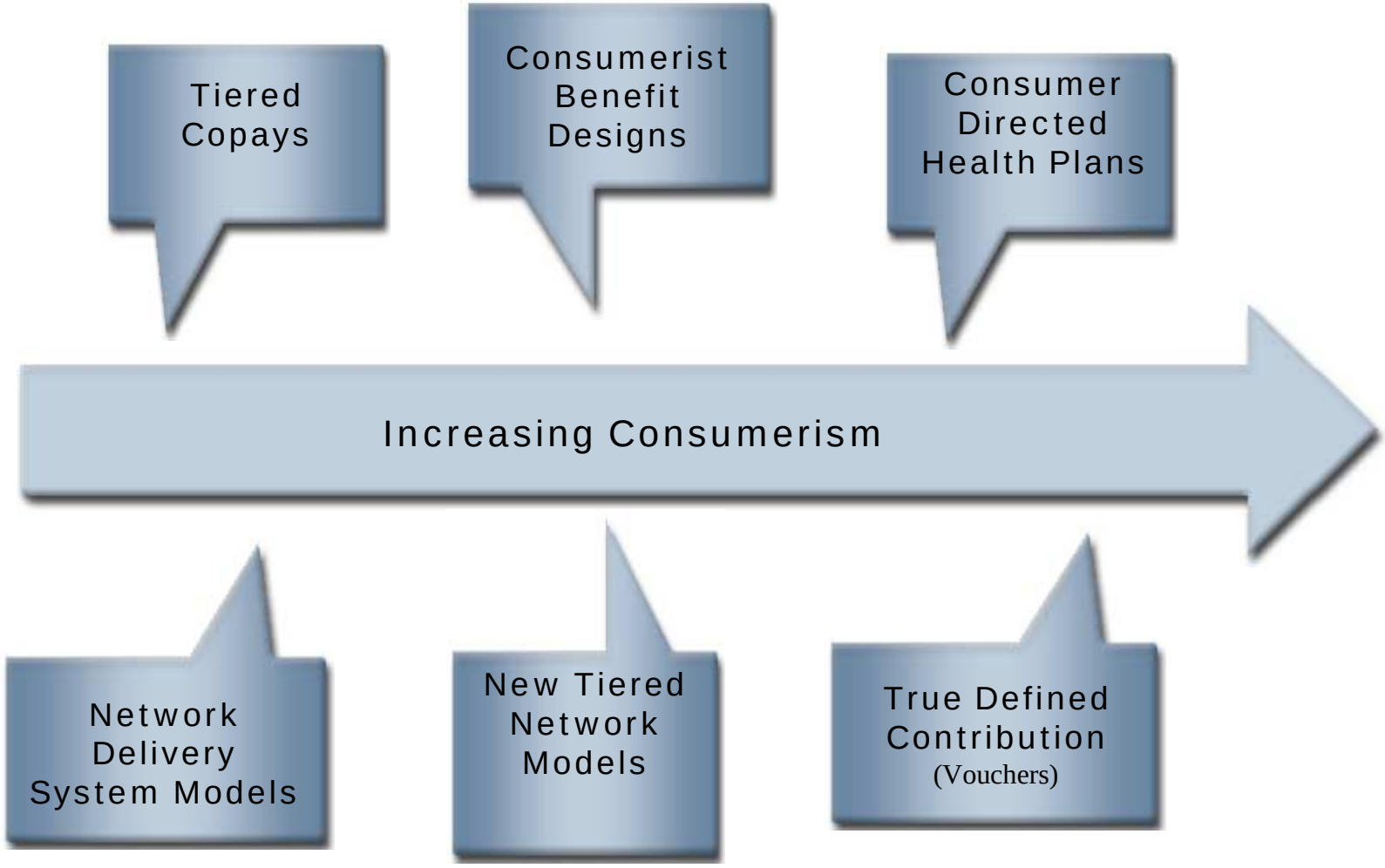
High Performance Networks

Considerations

- **High Potential Areas**
  - at least 5,000 participants
  - no more than 1 million residents
  - sufficient specialists for competition and access
  - low incidence of capitation

- **Potential Barriers**
  - Kentucky's any willing provider statutes
  - only viable in certain areas of the Commonwealth

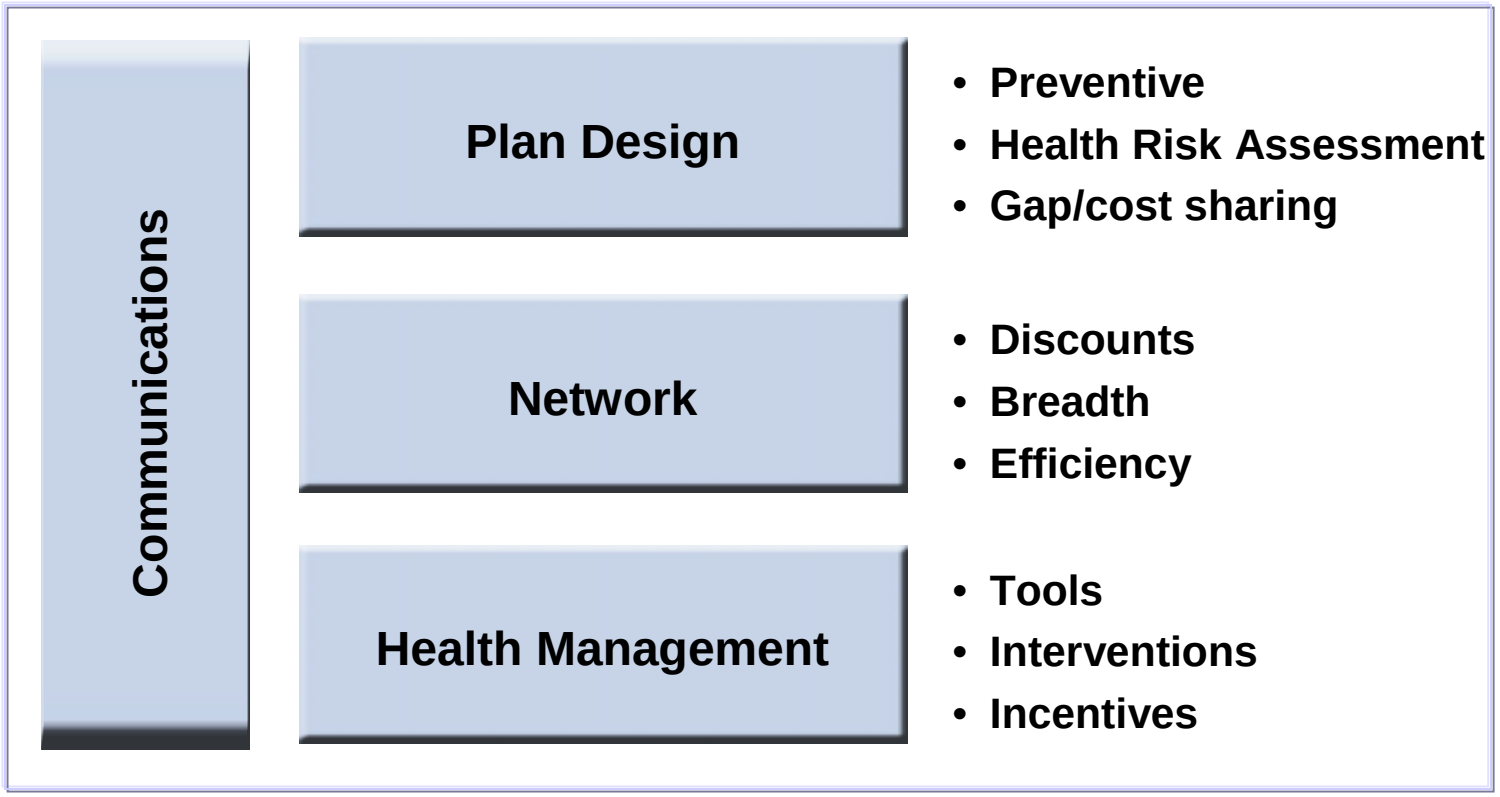
Promoting Consumer Accountability



Plan Designs Evolving to Support Consumerism

Today's Designs	Intermediate Changes	Future Designs
Copay based	Accounts for preventive services	Variable coinsurance with web-based tools to compare cost /quality prior to accessing care
Limited cost sharing	Increased cost sharing for discretionary services	"Buy-up" offerings for optional benefits (e.g. new technology, alternative medicine etc.)
Members insulated from true cost and lack comparative information	Increased coinsurance levels with elimination of arbitrary maximums for selected therapies	Exposure to true cost - marketplace transparency
Plan coverage equivalent (e.g., 90% for all services)		Plan coverage variable (e.g., preventive vs. discretionary vs. life threatening, etc.)

Consumer Directed Health Plans (CDHP)



Consumer Directed Healthcare Account-Based Plans

Deductible

$1,000

Health Reimbursement Account

$500

Member Pays

Bill

Bill

Bill

$$$

PPO Plan Co-insurance

Member 20%

Plan 80%

→

Plan Pays 100%

Variations:

- Incorporate incentive for favorable behavior
- Cover preventive care at 100%
- Provide incentive to use efficient providers

Consumer Education

- Self care
- Chronic illness management
- Provider quality and cost

Challenges to Consumerism in Health Care

- **Choice vs. Quality**
  - Most existing tools support benefit level decisions – consumerism will require support for provider and treatment level choices as well
  - Quality information is not readily available or adequately integrated into current decision support tools
- **Human Behavior**
  - “Old habits die hard”
  - Getting individuals to actively participate in own health care when they believe they are already doing so
- **Information Overload**
  - Employees will be overwhelmed by amount of data without effective information inquiry tools

State Initiatives

- **Colorado** *(The Associated Press State & Local Wire, September 15, 2002)*
  - average contribution increase of 39%
- **Washington**
  - increased cost sharing - Rx co-pays
  - increased employee contributions
- **California** *(The Associated Press State & Local Wire, April 17, 2002)*
  - employee contribution increases - ex. single $24; family $90 - $107 per month
  - studying tiered hospital networks
- **Oklahoma - stipulates provider reimbursements**
- **West Virginia - dictates provider reimbursements**

State Initiatives (cont'd)

- **Prescription Drugs** ***(Pittsburgh Post-Gazette January 12, 2002)***
  - **Purchasing coalition - New York and six other states**
  - **Medicaid (ME and FL) - requires prior authorization and/or limits number of name-brand medicines per month**
- **Pennsylvania**
  - **carves out DME, Rx and mental health**
  - **implementing disease management**
- **Illinois**
  - **contracts directly with hospitals in some areas**
  - **implementing disease management**

State Initiatives (cont'd)

- **South Dakota**
  - contracts directly with hospitals - DRGs for inpatient and ACG's for 14 outpatient services
  - web-supported disease management program
- **Minnesota**
  - state profiled care systems
  - member cost-sharing based on care system selected

Final Thoughts

- **Healthcare costs will continue to rise dramatically**
- **No single simple solution exists -**
  there is no silver bullet
- **To be successful, plan sponsors will have to pursue multiple new approaches**